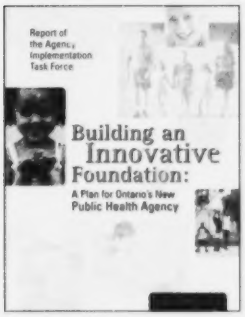
Final Report
of the Agency
Implementation
Task Force

From *Vision* to *Action*:

A Plan for the Ontario Agency for Health Protection and Promotion

March 2006



This report builds on the Agency Implementation Task Force's Part One Report, *Building an Innovative Foundation: A Plan for Ontario's New Public Health Agency, Part One, October 2005.*

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The Agency Implementation Task Force would like to thank the Strategic Planning and Implementation Branch of the Public Health Division of the Ministry of Health and Long-Term Care for its support and excellent work in the preparation of this report.

The Task Force would also like to acknowledge the valuable input provided by the following:

- Institut national de santé publique du Québec
- British Columbia Centre for Disease Control
- Participants in the roundtable discussions and the Agency Implementation Task Force Reference Panel

Letter of Transmittal

Dr. Sheela Basrur
Chief Medical Officer of Health and Assistant Deputy Minister
Public Health Division, Ministry of Health and Long-Term Care
Hepburn Block, 11th Floor
80 Grosvenor Street
Toronto, ON M7A 1R3

March 2006

Dear Dr. Basrur:

The Agency Implementation Task Force (AITF) is pleased to present its final report outlining our best advice on the implementation of a public health agency for Ontario.

The Task Force recommends that the agency adopt the name *Ontario Agency for Health Protection and Promotion* (referred to as 'the Agency'); this proposed name is used throughout the report.

In October 2005, we presented Part One of our report. It provided the necessary foundation upon which the government could begin developing the Agency. This final report reiterates the need to move forward quickly, integrates an overview of Part One, and builds on this foundation to provide our final recommendations regarding the Agency's operating structure, governance model, and phased implementation.

The Report outlines how the Agency could provide a valuable support function as part of an overall emergency framework. The report also contains our advice on approaches to modernise and align the vital role of the Ontario Public Health Laboratories within the overall structure of the Agency, proposed governance structure and suggested mechanisms to ensure effective coordination between Ministries and the Agency.

The case for a public health agency for Ontario is clear. It has been made by Dr. David Walker, Justice Archibald Campbell, Dr. David Naylor and countless others. It has also been reinforced repeatedly to the Task Force throughout our process in the submissions, presentations and opinions shared from across the spectrum of health care.

The establishment of a dedicated agency for health protection and promotion for Ontario will mark a milestone in the rebuilding of public health in Ontario.

We commend the Minister of Health and Long-Term Care and the government of Ontario for having made the historic commitment to a public health agency and we are honoured to have had the opportunity to contribute to this process. We thank those whose work has gone before us, and the many individuals and organisations who have taken the time to provide us with their advice and guidance. The dedicated staff of the Strategic Planning and Implementation Branch of the Public Health Division provided capable and energetic support to our efforts.

We look forward to the Ontario Agency for Health Protection and Promotion taking its place in Ontario's public health landscape to strengthen our collective capacity to protect and promote the health of all Ontarians.

Sincerely,

Members of the Agency Implementation Task Force

cc: Honourable George Smitherman, Minister of Health and Long-Term Care
Honourable Jim Watson, Minister of Health Promotion

Geoff Dunkley (co-chair) | Terry Sullivan (co-chair) | Michael Christian | Donald Cole | Ken Deane

Mae Katt | Alan Meek | David L. Mowat | Linda O'Brien-Pallas | Ruth Sanderson

Andrew Simor | Penny Sutcliffe | Ron Yamada | Jennifer Zelmer

Glossary of Acronyms

ADM	Assistant Deputy Minister
AITF	Agency Implementation Task Force
ARO	Antibiotic Resistant Organism
BCCDC	British Columbia Centre for Disease Control
CAO	Chief Administrative Office
CCO	Cancer Care Ontario
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CIHI	Canada Institute for Health Information
CIHR	Canadian Institutes for Health Research
CMOH	Chief Medical Officer of Health
CRC	Public Health Capacity Review Committee
EEMC	Executive Emergency Management Committee
EMO	Emergency Management Ontario
EMU	Emergency Management Unit
FIPPA	Freedom of Information and Protection of Privacy Act
HIU	Health Intelligence Unit
HPA	Health Protection Agency
HPPA	Health Promotion and Protection Act
ICES	Institute for Clinical and Evaluative Sciences
ICP	Infection Control Practitioner
IMS	Incident Management System
INSPQ	Institut national de santé publique du Québec
LHIN	Local Health Integration Network
LIS	Laboratory Information System
MCSCS	Ministry of Community Safety and Correctional Services
MHP	Ministry of Health Promotion
MHPSG	Mandatory Health Programs and Services Guidelines
MOH	Medical Officer of Health
MOHLTC	Ministry of Health and Long-Term Care
MOU	Memorandum of Understanding
MRSA	Methicillin Resistant Staphylococcus Aureus
NCC	National Collaborating Centre
NGO	Non-Governmental Organisations
OEMS	Office of Emergency Management Support
OHPRS	Ontario Health Promotion Resource System
OHSR	Ontario Health Status Report
OLIS	Ontario Laboratory Information System
OPHL	Ontario Public Health Laboratories
PHAC	Public Health Agency of Canada
PHERO	Public Health and Epidemiology Report Ontario
PHI	Personal Health Information
PHIPA	Personal Health Information Protection Act
PHRED	Public Health Research, Education and Development
PIDAC	Provincial Infectious Diseases Advisory Committee
RICN	Regional Infection Control Network
RRFSS	Rapid Risk Factor Surveillance System
VRE	Vancomycin Resistant Enterococci

Executive Summary

Ontario has clearly heard the well-grounded and remarkably consistent calls for the Province to strengthen public health capacity both locally and centrally. The work that has been undertaken by the Agency Implementation Task Force (AITF) has been influenced by and builds on the extensive work of others, as listed below:

- National Advisory Committee on SARS and Public Health, *Learning from SARS: renewal of public health in Canada* (Naylor Report)[1];
- SARS Commission, *Interim report: SARS and public health in Ontario* (First Interim Report of Justice Archie Campbell)[2];
- SARS Commission, *Second Interim Report: SARS and public health legislation* (Second Interim Report of Justice Archie Campbell)[3];
- Ontario Expert Panel on SARS and Infectious Disease Control, *For the public's health: Final report of the Ontario Expert Panel on SARS and Infectious Disease Control* (Walker Report)[4];
- Meat Regulatory and Inspection Review, *Farm to fork: A strategy for meat safety in Ontario* (Report of Justice Roland Haines)[5];
- Report of the Expert Panel on the Legionnaire's Disease Outbreak in the City of Toronto – September/October 2005, *Report Card: Progress on Protecting the Public's Health* (Walker)[6]; and
- 2005 Annual Report of the Chief Medical Officer of Health (CMOH) to the Ontario Assembly, *Building the Foundation of a Strong Public Health System for Ontarians*[7].

In June 2004, the Ministry of Health and Long-Term Care (MOHLTC) released *Operation Health Protection: An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario*.[8] This Report responded to a number of key recommendations made in the Walker Report and the first interim Campbell Report on SARS. *Operation Health Protection* committed the government to a series of measures to strengthen Ontario's capacity in a range of areas including developing and implementing a new public health agency.

In January 2005, the MOHLTC established the AITF to advise on developing a public health agency, to validate a mandate and structure, and provide an implementation plan to strengthen capacity in the areas of health protection and health promotion. Creating the Ontario Agency for Health Protection and Promotion (referred to in this Report as 'the Agency') presents a landmark opportunity to build an organisation through which we can strengthen both public health capacity and confidence going forward. The Agency is a key component of the renewal of the public health system. However, it is not an end in itself and must be seen as linked with the ongoing efforts to reform the public health system in the years ahead.

The Task Force used a range of approaches in completing its work, including literature reviews, cross-jurisdictional analyses, and an examination of best practices in a range of areas. The AITF sought ongoing advice and guidance from national and international leaders in existing public health agencies, and from numerous public health and health care associations and groups.

We acknowledge the advice and support we have received from both the Institut national de santé publique du Québec (INSPQ) in Quebec and the British Columbia Centre for Disease Control (BCCDC). We have also benefited from having a Public Health Agency of Canada (PHAC) representative on the Task Force. The examples and lessons learned from these agencies have been valuable and informative in helping shape our thinking. They have also reinforced for us how the establishment of an Ontario agency is a critical and very welcomed step not just for Ontario, but for Canada as a whole.

National and international models and best practices, however, provided us with only one part of the picture. We have balanced this by working hard to better understand and respond to the documented needs identified here in Ontario. We have examined in detail the specific gaps identified through the Public Health Capacity Review Committee (CRC) at the local level and reviewed the findings generated through that process. In particular, we have consciously examined the local needs associated with training, professional development, tools and assistance. We are indebted to all those who informed this work as these consultations significantly influenced our deliberations.

Since the SARS outbreak, much has changed in Ontario in public health, in emergency management and in the evolving shape and organisation of the health care system as whole. In undertaking this work, the Task Force has responded to these changes and tried to avoid simply recommending actions based upon what was, or was not, in place during the spring and summer of 2003.

Changes have been made since 2003 and there have been some clear improvements both in structures and processes to enhance public health capacity, infection control and emergency preparedness. However, while we recognise this progress,it is critical to the health of Ontarians that this momentum be sustained in the years to come.

The Agency presents an opportunity to build on the progress to date by adding a critical component linked to ongoing parallel efforts to reform and renew the public health system. The Agency is a key part of this endeavour

In the end, we will have genuinely made a difference if our collective ability to access timely, credible, evidence-based knowledge, tools, support and advice from within our own jurisdiction is strengthened through the Agency's work in the years to come.

The Part One Report *Building an Innovative Foundation: A Plan for Ontario's New Public Health Agency* (October 2005)[3] put forward a proposed mandate, vision, mission and core values for the Agency:

Mandate

To provide scientific and technical advice for those working to protect and promote the health of Ontarians.

Vision

We will be an internationally recognised centre of expertise dedicated to the protection and promotion of the health of all Ontarians through the application and advancement of science and knowledge.

Mission

We are accountable to support health care providers, the public health system and partner Ministries in making informed decisions and taking informed action to improve the health and security of all Ontarians through the transparent and timely provision of credible scientific advice and practical tools.

Core Values

- Responsiveness;
- Relevance;
- Credibility;
- Collaboration; and
- Innovation.

The Task Force's Final Report builds on the Part One Report and provides greater detail on the proposed Agency's:

- Governance and Accountability;
- Ministry/Inter-Ministry Liaison;
- Organisational Design;
- Legislative Authority;
- Ontario Public Health Laboratories;
- Support in Emergency and Exigent Circumstances; and
- Phasing-In.

Operational Approach

To effectively execute its mandate, the Agency will require broad connections and affiliations with partners in key sectors. The Agency should establish formal partnerships, as appropriate, with academia, research bodies, non-governmental organisations and key health organisations.

While it should fall to the Agency's Board to determine how best to structure partnership agreements with appropriate institutions, we believe there are several principles and elements worthy of consideration:

- The Task Force proposes that the principles of clarity, credibility, transparency, practicality, mutual benefits, a focus on results, and clearly defined exit rules guide the development of the Agency's partnerships.
- The Task Force has outlined a number of key elements of successful partnerships and identified several priority partnerships that need to be established in the Agency's early stages to help it carry out its mandate.

While there is an increasing number of virtual and highly decentralised approaches that have been pursued in developing research institutes and consortia at the national level, a number of the tasks that the Agency would be asked to perform and the strong central relationships it would need, place very natural limits on how decentralised it can be.

The AITF believes that the Agency needs a strong permanent physical presence in the downtown Toronto core to provide easy access to Ministry partners, the Chief Medical Officer of Health (CMOH), the Emergency Management Unit (EMU) and the large concentration of research, medical and scientific resources available.

In keeping with its philosophy of building upon existing capacity and infrastructure and the need to ensure that the work of the Agency meets the needs across Ontario, the AITF recommends that the Agency also foster a coordinated approach to linking with and enhancing the work underway through Public Health Units, the existing Regional Infection Control Networks (RICN) and the proposed regional networks for research and knowledge exchange. Ensuring these forms of connectedness are in place will help ensure the functions and mandate of the Agency remain grounded in serving all of Ontario.

Governance and Accountability

To develop the proposed governance and accountability structures for the Agency, the Task Force studied the governance models in place for a range of existing public health agencies in other jurisdictions, examined best practices from recent literature and guidelines, and examined the experiences of a range of Ontario agencies.

To support the objective of building a credible, non-partisan provider of scientific and technical advice and support, the Task Force recommends that the Agency be established with an arm's-length relationship to government. To secure this status, the Task Force recommends that the Agency be created through special purpose legislation and be established as a scheduled agency of the Crown. This form of legislated approach is consistent with the approach taken in Quebec, and at the national level in Finland, the UK, Ireland and an increasing number of European states.

The success of any agency of this type, however, is not primarily a question of legislative authority but, as Justice Campbell has rightly observed, it will rest in large part upon its moral authority.[10] The confidence and trust that the Agency can build over time, both with its Ministry partners and the broader public health and health care communities, will be the true source of its earned autonomy.

A first step for Ontario on this path is ensuring the Agency is well governed and well run and that expectations and accountabilities are clear. To that end we have proposed a range of specific measures that could help ensure effective governance.

Strong governance and accountability mechanisms, defined processes for communication and liaison, and clear emergency support roles as part of an overall framework are consistent with an arms-length role. They are the necessary processes that help build trust between partners and ensure that scientific autonomy can co-exist effectively with the operational requirements of multiple Ministry and field partners.

As a scheduled agency of the MOHLTC, the Agency should be required to submit Annual Reports and ensure that these reports are made public, thereby demonstrating how its funding links to the outcomes and objectives set out in these plans. The agreements detailing the roles and responsibilities of the Agency and MOHLTC should be

outlined in the form of a Memorandum of Understanding (MOU), which is subject to regular review by both parties to ensure its ongoing relevance and accuracy.

Board of Directors

The Task Force recommends that a skill-based Board of Directors be appointed to govern the Agency. The Board would be legally responsible and accountable for the overall stewardship of the activities of the Agency including:

- Providing strategic direction to the organisation;
- Ensuring the execution of Strategic Plans comprised of both provincial priorities and needs identified in consultation with the field;
- Ensuring that financial accountability controls are in place and adhered to;
- Selecting, hiring and reviewing the performance of the Chief Executive Officer (CEO) for the Agency;
- Being accountable for the operations of the Agency to the Minister of Health and Long-Term Care through the Board Chair; and
- Submitting Annual Reports to the MOHLTC with copies made available to the Ministry of Health Promotion (MHP) for subsequent tabling in the Legislature.

The AITF recommends that Board members be selected through an open and transparent process. The Task Force suggests that an open call be undertaken to develop a long list of potential candidates who would be screened against a clear set of competencies. From the resultant short list, an external selection body would recommend to the Minister of Health and Long-Term Care an initial slate of candidates for consideration for Board membership and subsequent formal appointment.

To found the Agency, the AITF recommends that a small core group of between five and seven members be appointed, with these initial positions being supplemented at a later stage to create a full Board complement of thirteen people.

Board members should be screened to ensure that they have a set of *standard* Board skills including an appropriate understanding of governance, financial and legal issues, ability to work as members of a team, and think strategically. In addition to these general skills, those undertaking Board selection must also ensure that *specific* competencies, including knowledge of public health and health system organisation are reflected in the overall Board makeup. The AITF also recommends that a seat be reserved on the Board for a public representative, who meets the standard skills set out above.

The Board should also be responsible for hiring a CEO who would serve as the operational administrator and leader of the Agency, and who would be accountable to the Board. The CEO should possess critical abilities including scientific and public health/health sector leadership skills, and an ability to foster academic partnerships and act as champion for the Agency.

In hiring the first CEO, the Task Force strongly recommends involving the CMOH in both the screening and selection process. A condition of success for the smooth creation of the Agency will be the working relationship that develops between the CEO and the CMOH. This is an extremely important factor in the experience of all the jurisdictions operating with an arms-length agency model, regardless of the formal legal structure in place.

The Task Force recommends that four standing committees be structured to advise the Board: Strategic Planning, Scientific Advisory, Audit, and Governance. The Governance Committee should be comprised of only Board members, whereas the other three committees should be made up of both Board and non-Board members. This Report details our rationale for this approach and the potential role and function of each of these Committees.

The Task Force recommends that the CMOH participate at Board meetings and be a member of the Strategic Planning Committee in order to formally provide a strong liaison between provincial Ministries and the Board. While we anticipate a consensus form of operation for the Board, formally, the CMOH should not vote at Board meetings. The actual or potential role of the CMOH in approving funding and/or directing the activities of the Agency in exigent circumstances suggests that it is appropriate that a degree of separation be retained.

Ministry/Inter-Ministry Liaison

The Task Force recognises that the proposed mandate of the Agency and its areas of specialisation have relevance to a range of Ministries (e.g Ministries of Health Promotion, Environment, Labour, Agriculture, Food and Rural Affairs, Children and Youth Services, and Research and Innovation). We anticipate that the Agency will undertake work that frequently extends beyond traditional Ministry silos. This, in part, is reflective of the diversity of Ministries who have a direct reliance upon or interaction with public health in Ontario.

As such, there is a need to develop structures and supports that will ensure effective cross-Ministry input and communication. To this end, the Task Force recommends that a series of coordinating mechanisms be put in place through the position of the CMOH to ensure Ministries' input into the priority setting and strategic planning process of the Agency.

While it is important that the Agency be linked to multiple Ministry partners, it is also essential that a clear single line of accountability exist to one designated Minister. For this reason, we recommend that the Agency be accountable through the Chair of the Board directly to the Minister of Health and Long-Term Care, who would be accountable to the Legislature for the activities of the Agency.

We acknowledge the important role of the MHP, which shares extensive common interests in health promotion, chronic disease and injury prevention. As such, the CMOH, who currently serves as an Assistant Deputy Minister (ADM) in MOHLTC and MHP, is the logical connection between the two Ministries and the Agency.

The CMOH should also be designated to ensure processes are in place to coordinate the input and advice from other Ministries through a broader Inter-Ministry Committee. This committee would coordinate requests to undertake initiatives and projects consistent with the Agency's mandate and prioritise them for submission to the Agency for inclusion in the Strategic Plan.

Priority Setting (Field Input)

Balancing the priority initiatives identified at the provincial level, the AITF is recommending that a series of mechanisms be put in place to ensure that there is input into the Agency's Strategic Plan from the field (Public Health Units and health care providers). These mechanisms could also include formal links to the newly developing RICN and the creation of a coordinated network in the field of public health knowledge exchange and training. Supplementing these approaches would be topic and issue specific fora allowing for direct input into priority setting.

Organisational Design

The Task Force recommends that the Agency have a clearly defined role focussed upon a range of defined activities and that appropriate Ministries continue to be responsible for key stewardship and oversight functions including:

- Policy development;
- Enforcing compliance of the Mandatory Health Programs and Services Guidelines (MHPSG)[11];
- Human resource planning;
- Emergency management;
- General communications;
- Funding of Public Health Units and other health care facilities;
- Formal federal/provincial liaison with Health Canada and PHAC;
- Setting standards; and
- Legislation and regulatory issues.

The Task Force envisions the Agency having six functions in three areas of specialisation with one cross-cutting theme in order to serve its primary client base of health care providers, Public Health Units, and partner Ministries.

Functions:

- Surveillance and Epidemiology;
- Research;
- Knowledge Exchange;
- Laboratory Services;
- Professional Development; and
- Communication.

Areas of specialisation:

- Infectious Diseases (including infection prevention and control);
- Health Promotion, Chronic Disease and Injury Prevention; and
- Environmental Health.

Cross-cutting theme:

- Support in Emergency and Exigent Circumstances.

In each function and area of specialisation, the Agency should be focussed on:

- Providing a single window of access to expertise (common science);
- Translating science and research into practical tools and useable information (common language); and
- Supporting collaboration, information exchange and sharing of best practices among existing and new communities of practice.

The Agency should have a role in risk communication, with a distinct focus upon refining approaches to effectively communicate scientific and medical information in a manner tailored to the practical needs of the user to assist decision making at both the local and Provincial levels.

Legislative Authority

The Health Promotion and Protection Act (HPPA)[12] specifies the responsibilities of local Boards of Health, and local Medical Officers of Health (MOHs) for managing public health programs and services required under the HPPA. This *Act* also provides for a series of powers for MOHs to take actions to mitigate or control risks to human health and sets out the obligations requiring the reporting of specified diseases to the Public Health Unit and the subsequent obligation of the Unit to report these to the MOHLTC.

The AITF reaffirms the role played by local MOHs and strongly supports the philosophy of continuing to vest responsibility for public health management and response to outbreaks and threats to health, first and foremost at the local level. The role of the Agency should not be, in any way, to weaken existing structures, but rather support reinforce and enhance local responses when required.

Collectively, our primary focus should also be on improving our ability to anticipate and prevent threats to our health before they occur, and to contain them locally when they do occur. Key to this is ensuring that existing legislation is clear and up to date.

In this regard, we are aware of Justice Campbell's extensive work documenting some of the shortcomings and gaps in the current powers of MOHs to uphold the HPPA and fulfill their mandate.[13] We do not, however, believe that creating specific overriding legislative powers for the Agency is appropriate to address these gaps.

Justice Campbell in the Second Interim Report of the SARS Commission has called for significant review of the powers and duties of both MOHs and the CMOH under HPPA.[14] This work is necessary and needs to be undertaken. It is through this type of comprehensive review of the legislative framework for public health that the overall question of the balance of appropriate powers held locally and provincially should be resolved.

Before the completion of this review, we do not recommend a piecemeal approach to dividing powers among the CMOH, the local MOHs and the Agency. Rather, the Task Force believes that the focus should be on ensuring that the requirements placed upon Boards of Health and the powers held by the MOH, the CMOH and Minister are appropriate. To that end, the current reporting requirements set out in the HPPA should remain in place with the Agency providing complementary analytical, technical and field support, as required.

The Task Force also recommends that through contractual and legal means, the CMOH be vested with the authority to mobilise the Agency's resources to assist in addressing urgent and emergent issues, when these are consistent with the Agency's mandate and in the opinion of the CMOH, the skills of Agency personnel are required.

To that end, we are recommending that the Agency be staffed with both the capacity and requirement to provide direct field support in emergency or exigent health-related circumstances. The CMOH will activate the involvement of the Agency. Once deployed, the Agency will operate under the chain of command established by the Incident Management System (IMS) in place, either in the field in an exigent circumstance or through the Executive Emergency Management Committee (EEMC) in an emergency. To formalise the power of the CMOH to activate the Agency's involvement in emergency and exigent circumstances, we recommend that, through the MOU and appropriate contractual and legislative means, this be enshrined in the founding documents of the Agency.

Ontario Public Health Laboratories (OPHL)

Dr. Sheela Basrur, the CMOH, observed in her 2005 Report to the Legislature that "the best and possibly only hope for public health laboratory renewal lies in Ontario's commitment to create a provincial Public Health Agency."[15]

The AITF supports Dr. Basrur's statement and believes that placing operational responsibility for the OPHL with the Agency will be critical in helping to overcome a number of long-standing and well-documented challenges faced by the OPHL in recent years.

First, the proposed incorporation of public health laboratory functions under the Agency would address the organisational need for a stronger formalised intersection of the OPHL with the broader surveillance and epidemiology functions of public health and infectious disease control.

Second, the relocation of select core Central Public Health Laboratory services from the existing facilities to a central Agency site would address, at least in part, the current facility constraints faced by an aging Central Public Health Laboratory. As proposed in the Part One Report, co-location provides an opportunity to modernise the laboratory's physical plant and simultaneously help to bring its functions into more organised contact with the broader research community and related functions of the Agency.

Third, we believe that the ability of the OPHL to attract and retain the skilled staff it requires in microbiology, genetics, and other disciplines in short supply, is contingent on enhancing and supporting the promotion of research excellence. It is also contingent on providing both the setting and the mandate to attract personnel with these skill sets. The move to an agency with a clear role in research and innovation can only assist in this effort.

The Task Force recommends a phased transfer of the OPHL in its entirety to the Agency by the end of 2008. It is clear that the need to focus and modernise the capacity of the OPHL cannot be achieved by partial measures aimed at the Central Laboratory's functions alone. We believe that improving the functioning of, and support to, regional laboratories as part of a linked system is the right approach and will avoid the danger of a fragmented laboratory system.

Work on the transition needs to begin immediately to ensure that the laboratory services and staff are integrated in an organised way that minimises service disruptions and is undertaken in manageable stages respecting the need for continuity. We would underscore the need for a transitional plan that is agreeable to all parties. To this end, we recommend establishing a formal transition group to expedite this work, with external support as required to assist in the transition. The Task Force has also prepared a pre-transition list of requirements to begin the suggested three-phase transition be initiated as quickly as possible.

Support in Emergency and Exigent Circumstances

In the area of emergency management support, the Task Force has spent considerable time mapping out the specific place of the Agency within the overall emergency management framework.

Emergency Management Ontario (EMO), which has a designated provincial role associated with general emergency preparedness, has been supplemented by specific health sector and MOHLTC organisational and planning capacity through the EMU. This unit was created after SARS and reports to the CMOH. We see tremendous value in the work that has been undertaken by this unit and the contribution it is making to improving readiness through augmenting Ontario's health sector planning capacity.

In undertaking its work, the AITF has ensured that its recommended approach fits into the existing emergency management framework. We have all learned through SARS that clarity regarding who is in charge is critical. To that end, we are recommending that in any formal emergency circumstance, the Agency function under the existing emergency framework, acting as a central scientific and technical resource to be drawn upon as required.

In circumstances which, in the opinion of the CMOH, present an urgent or exigent threat to human health, but are still below the level of a formal declared emergency, we recommend that the CMOH be authorised to call on the resources of the Agency to provide support as required.

We do not see the Agency duplicating the valuable work being undertaken by the EMU. We see great importance in this planning work continuing within the MOHLTC. Rather, we see the Agency being a vehicle to supplement these activities by providing ready access to a pool of scientific and technical areas of specialisation on a permanent and ongoing basis. We would see a working partnership developing between EMU and the Agency jointly improving the capacity for risk analysis and the development of approaches to specialised communication. We also see extensive opportunities for the Agency to undertake enhanced outbreak modelling capacity to provide better guidance to planners on health-related emergency scenarios.

In an emergency situation, we recommend that the CEO be a member of the Executive Emergency Management Committee (EEMC) of the MOHLTC, and, as such, function under its direction as part of a centrally led coordinated response mechanism.

Phasing In

In the final component of our report, we have attempted to provide a series of steps that could be undertaken to

establish the Agency and identify areas of early activity for the first three years.

We would caution, however, that the final task of determining the priorities and precise timing of the areas of activity to be addressed will need to made through the strategic planning processes we have outlined. This Strategic Plan, under the model we are proposing, will ultimately be determined by a process of input from both the field and Ministries into the new Agency. As such, dictating what will be the first five initiatives launched by the Agency is not something that this Task Force has the authority to determine. This will fall to others. The plan outlined in this Report broadly illustrates certain critical supports and informational needs that we believe the Agency would be well positioned to address.

Funding

Dr. David Walker had, in the final report of the Expert Panel on SARS and Infectious Disease Control, recommended an operational budget of $45M[16] excluding existing base expenditures associated with laboratory operations. Dr. Walker had further recommended a capital allocation of $35M and $3.5M in design and development costs.

A range of variables which are outside the responsibility of this Task Force complicate final approaches to funding. Firstly, and most significantly, any decisions and costs associated with the formal OPHL review which we understand is almost finalised will have to be taken into consideration. Secondly, the decision and timing of laboratory services transition will adjust the overall budget totals significantly. In addition, project reviews, such as the review called for in our Part One Report of the *Ontario Health Promotion Resource System* (OHPRS), are required to determine what, if any, roles of existing entities funded by the Province in the area of health promotion might be assumed by the Agency.

Acknowledging these significant variables, we would recommend an allocation consistent with the range offered by Dr. Walker but with the following considerations.

- Laboratory transition and modernisation costs should be considered as additional costs over and above any base allocation for the Agency.
- Areas with specific project funding which align with the Agency mandate should be examined for consideration for transfer to the new organisation at a later date. In particular, existing PHAC funding for Ontario's National Collaborating Centre (NCC) in Public Health Tools and Methodologies should be re-assigned to the Agency by 2007/08.
- The Agency should be permitted and indeed encouraged to seek access to third-party funds, particularly in the area of research, to supplement its base allocation without these funds affecting core Provincial funding.

Conclusion

In concluding, we would like to acknowledge and thank all those who have provided us with their advice, support and guidance throughout this process. We have benefited greatly from this input.

Creating a new Agency is an enormous undertaking and will take time to get right. We will need to learn as we go, as those who have gone before us have had to do. We cannot possibly know all of the answers today, nor can all of them be prescribed in advance by this Task Force. Looking back to SARS and forward to the risks that may face us in the coming years, we are in no doubt whatsoever that creating the Ontario Agency for Health Protection and Promotion is the right thing to do.

We need to forge a new partnership between the way that Ministries, health care providers and researchers interact around the shared objectives of equipping ourselves with the best available knowledge, tools and supports to protect and promote the health of all Ontarians. To do this, we need to harness and draw on the skill and knowledge buried in structures that too often are isolated and disconnected from each other.

We are honoured to have had the opportunity to contribute to this historic undertaking and hope that our work can provide some assistance in meeting some of the challenges ahead. It is our earnest hope that a few years from now Ontario and Ontarians will be justly proud of their Agency and truly see a Province that indeed fully learned from SARS, remembered and acted.

Recommendations

Maintaining the Momentum

1. The MOHLTC should ensure that a dedicated transition support group, with continued access to appropriate internal and external expertise, is in place by spring 2006. This team should assist with the phased implementation of the recommendations of the A'TF and, in particular, with planning and support required for the effective transition of laboratory services to the Agency.

Creating the Agency

2. The Agency should be established through special purpose legislation.

    a. The Agency should be a scheduled agency of the Crown.

    b. The Agency should be granted the necessary powers to access and hold third party funds to enhance its research capacity.

    c. The Agency should be granted the legal authority to collect, use and disclose data in a privacy-sensitive manner.

    d. Existing legal reporting requirements to Public Health Units and to MOHLTC as stipulated in the HPPA should remain in place subject to the overall results of a full HPPA review.

Governance

3. The Agency should be functionally arm's length from the MOHLTC and be governed by a Board of Directors.

    a. A Board of Directors for the Agency should be in place by late 2006, starting with a core of five to seven members and moving gradually to a full Board of thirteen members.

    b. Members of the Board should be selected through a transparent, non-partisan process involving appropriate external expert advice. Board members should be appointed by Order in Council with staggered terms.

    c. Membership of the Board should represent a suitable breadth of skills and competencies reflective of the Agency's mandate and include a public health presence and a public representative.

d. Clear reporting relationships should be established whereby the Chair of the Agency's Board is directly accountable to the Minister of Health and Long-Term Care. The Minister would be, in turn, accountable to the Legislature for the Agency's activities.

e. A series of standing committees should report to the Board, including Governance, Strategic Planning, Scientific Advisory and Audit. Membership on the Governance Committee should be Board members only. The remaining committees should also include non-Board members.

f. The Strategic Planning Committee should be given the task of recommending a multi-year Strategic Plan that aligns with both Provincially identified and field priorities to be approved by the Board.

4. The Board should be required to establish by-laws and appropriate policies including those related to ethical governance practice and conflict of interest to guide the effective management and operations of the Agency.

The Agency's Activities

5. The Agency's primary clients should be health care providers, Public Health Units, and partner Ministries.

6. In undertaking its activities the Agency should be guided by relevance to all of Ontario, and as such we recommend that the Agency has in place mechanisms to ensure that issues pertinent to First Nations/Aboriginal communities are appropriately included.

7. The Agency's initial areas of technical specialisation should be: infectious diseases (including infection prevention and control); health promotion, chronic disease and injury prevention; and environmental health. These areas should be understood to include family health as appropriate to each area of specialisation.

8. The Agency should provide the following functions: surveillance and epidemiology; research; knowledge exchange; laboratory services; professional development; and communication.

9. Support in emergency and exigent circumstances should be a theme that cuts across the Agency's areas of specialisation and functions and be structured to allow for response and support within the overall provincial emergency management framework.

10. The Agency should adopt and promote the practice of using multi-disciplinary teams, which work together across the various areas of specialisation and functions to ensure the efficient, flexible and rapid flow of information and expertise. As appropriate, these teams would include people outside the Agency from the field and various Ministries.

11. The Agency should work with MOHLTC in order to put into place appropriate library and information technology infrastructure that allows for optimal alignment and connectivity to existing systems established by the Province.

Strengthen and Align Ontario Public Health Laboratories

12. A reformed and strengthened OPHL should be a core component of the Agency's activities. The implementation of AITF recommendations contained in its Report should be closely aligned with any final recommendations emanating from an operational review of the OPHL.

13. The AITF recommends a phased implementation of transition of the OPHL into the operational structure of the Agency by the end of 2008.

14. The transition team should assess the following critical areas:
    - Workforce strategy and planning;
    - Logistics associated with the acquisition and move to new laboratory space for core Central Laboratory functions; and
    - Implementing the a single integrated Laboratory Information System (LIS).

15. The Agency should ensure that regional laboratory renewal is addressed.

16. Select Central Laboratory testing should be physically co-located with the Agency and a detailed review of the current testing menu should be undertaken by 2008.

Funding

17. The Agency should be funded by the MOHLTC on a multi-year basis, subject to an annual review based upon its approved Strategic Plan. Projects outside the Strategic Plan would need to be considered for supplementary resources where required.

    a. The Agency should receive initial annual funding of at least $45M as recommended in the Walker Report excluding existing base expenditures and costs associated with recommendations from the OPHL review. Thereafter, funding should be on a multi-year basis.

    b. Existing funding for the OPHL including overhead and centralised support costs should be transferred in whole to the Agency upon completion of the required transition planning.

    c. The Agency should be granted the right to hold third-party funds e.g. project-based funding and national research grants consistent with the Agency's objects, without these amounts affecting core provincial funding.

    d. Existing PHAC funding for the NCC in Public Health Tools and Methodologies should be re-assigned to the Agency by 2007/8.

18. The Agency should be granted the authority to access supplementary funds in an emergency or exigent circumstance, equivalent to three months of the operating budget of the Agency.

Accountability and Reporting

19. The Agency should submit performance plans to the MOHLTC well in advance of the new fiscal year. The results of the activities contained in these plans should then be documented in Annual Reports submitted to MOHLTC and made publicly available. The Reports should forecast financial projections over a three-year period and be aligned with the overall Strategic Plan once the Agency is mature.

    a. Periodic external reviews of the Agency should be carried out to assess and evaluate its performance.

    b. The Agency should submit a formal Annual Report to the Minister of Health and Long-Term Care, for subsequent tabling in the Legislature, on activities of the Agency after its second year of operations. This would provide time for the Agency to recruit staff and initiate Agency functions. The Annual Report would monitor progress against the proposed plan from the previous year, report the funding received and spent, and highlight issues for the coming year.

20. The Chair of the Agency Board should be formally accountable for the operations of the Agency to the Minister of Health and Long-Term Care.

    a. The accountability and reporting relationship should be outlined in an MOU.

    b. The MOU should be reviewed on an annual basis and updated at least every five years.

Working with Partners

21. The MOHLTC should develop a mechanism based on models outlined in this Report to coordinate the process by which other Ministries submit their requests or proposals for specific projects or initiatives involving the Agency that fall outside the Agency's approved Strategic Plan.

22. The Agency should encourage project-based teamwork and cross-sector participation, through appropriate agreements with the Ministries and the Agency's partners, including non-governmental organisations (NGOs), academia, health care providers, and public health practitioners.

23. The Agency should have an internal intellectual property policy consistent with its mandate as a means to ensure clarity in any anticipated academic affiliation or other agreements.

Research and Knowledge Exchange

24. The Agency with the MOHLTC should support the development of a province-wide network for public

health research, training and knowledge exchange. The network should build upon existing capacity and be structured to support access to training and knowledge exchange resources on an equitable basis. Where appropriate, the network should begin by linking with other networks (e.g. RICNs, Tobacco Control Area Networks and Public Health Research, Education and Development (PHRED) programs). The network will evolve over time, but should be established by early 2007. Selection of potential partners in the network should be transparent and based upon:

- Demonstrated contribution to the field of public health;
- Broad-based collaboration and academic partnerships;
- Demonstrated regional partnership; and
- Alignment with the Agency's Strategic Plan and objectives.

25. The Agency should take a lead role in developing a three-year rolling province-wide agenda for public health research and knowledge exchange relevant to Ontario public health practice and policy, including an implementation plan and timeline for activities.

26. The Agency should, at minimum, draw upon the available provincial financial resources in the PHRED program. Furthermore, we recommend that the Agency assume direct oversight for the provincial budget component of the PHRED program by April 1, 2007.

Chief Medical Officer of Health Roles

27. The CMOH should attend all of the Agency's Board meetings. To support this, advance notice and materials should be provided to the CMOH. On issues where the Board may be required to vote, the CMOH should be considered non-voting. It is not recommended that the CMOH be permitted to send designates to the Board.

28. The CMOH should be designated as the formal liaison between the MOHLTC, the MHP and the Agency. Consistent with this role, the CMOH should be responsible for establishing the Intra-Ministry and Inter-Ministry Committees required to provide provincial priorities for undertaking by the Agency.

29. The CMOH should have membership on the standing Strategic Planning Committee of the Board of Directors, thereby ensuring a direct transmission of priorities identified at the provincial level.

30. The Agency should be required through appropriate legislative and contractual means to ensure the availability of core scientific and technical capacity for deployment in emergency or exigent circumstances when required.

Ministry Roles

31. The MOHLTC and MHP, as appropriate, should maintain the lead role and responsibility in the following areas:

    a. Development and review of legislation and regulations;

    b. Policy development;

    c. Adoption of program standards;

    d. Ensuring compliance and accountability with standards and guidelines;

    e. Formal public health human resource planning, assessment and training;

    f. Emergency management activities (with EMO and other relevant Ministries);

    g. General health communication to practitioners, professionals, the public and the media;

    h. Funding of Public Health Units and health care facilities, and ensuring accountability for the use of these funds; and

    i. Maintaining direct relationships with Federal departments such as Health Canada and PHAC through established Federal/Provincial/Territorial processes, except where such responsibility is delegated to the Agency.

Support in Emergency and Exigent Circumstances

32. In emergency situations that have health impacts, the CMOH, acting within the Provincial framework and under the EEMC, activates the Agency's involvement. Once deployed, the Agency operates within the established IMS structure and chain of command in place.

33. The CEO should be a formal member of the EEMC and related structures as required in an emergency.

34. The Agency should be available to provide technical and scientific advice and support to the MOHLTC, including where required field support capacity before, during and after an emergency with health impacts or in exigent circumstances.

Leadership

35. The Board of Directors should select and hire the CEO of the Agency through a transparent recruitment and selection process.

    a. The CEO should possess critical abilities including scientific and public health leadership skills, and an ability to foster academic partnerships and act as champion for the Agency.

    b. The Board should be responsible for assessing the performance of the CEO.

36. The CEO should not be a member of the Board, but should attend and participate in Board meetings as required except on matters pertaining to the evaluation of the CEO's performance.

37. Board meetings should be open to the public, with the Board reserving the right to go into executive session as required.

38. The Board should function to the extent possible on a consensus basis.

Chapter 1

Setting the Stage

Context

Operation Health Protection

In response to the recommendations contained in the Walker Report on SARS[1] and the first Interim Report of Justice Archie Campbell, *SARS and Public Health*[2], the Ministry of Health and Long-Term Care (MOHLTC) released *Operation Health Protection — An Action Plan to Prevent Threats to Our Health and to Promote a Healthy Ontario* on June 22, 2004.[3]

A key strategic priority of this three-year action plan to strengthen public health was a landmark commitment to create a new arm's-length public health agency for Ontario (now recommended to be called the Ontario Agency for Health Protection and Promotion or 'the Agency' in this Report), dedicated to preventing and controlling disease and promoting health with the following core functions:

- Enhanced and specialised public health laboratory services;
- Infectious diseases (including infection control and communicable disease capacity);
- Emergency preparedness assistance and support;
- Health promotion, chronic disease and injury prevention;
- Risk communications; and
- Research and knowledge exchange.

The goal of the Agency, as stated in *Operation Health Protection*, would be to "strengthen Ontario's capacity to provide scientific and technical advice for and within the health sector in the areas of health protection and promotion." [4] The present government has made a commitment to establish this Agency with a formal Board structure in place by 2006/7.

Agency Implementation Task Force

Operation Health Protection also made a commitment to establish an Agency Implementation Task Force (AITF) to act as an advisory body to the MOHLTC to provide guidance on the potential design and functioning of the new Agency. The AITF was formally struck in January 2005 with a mandate to:

- Validate the Agency's proposed mandate, key functional areas, structure and governance;
- Recommend operational public health responsibilities for the Agency and delineate its roles and responsibilities in relation to those of the MOHLTC, academia, the broader health system, and the Public Health Agency of Canada (PHAC) and its National Collaborating Centres (NCC); and

- Recommend a comprehensive three-year implementation plan for the Agency, including infrastructure, financial requirements, human resources and transition planning.

The AITF has met regularly since early 2005 and in October 2005 issued a Part One Report. This final Report builds on the earlier work and provides additional detail in a number of areas with particular emphasis on emergency support roles and relationships, laboratory transition and specific governance and coordination issues related to the establishment of the Agency. (See Appendix 1 for the full terms of reference for the AITF.)

Validating Our Work

The Task Force used numerous strategies to validate the proposed areas of specialisation and functions of the Agency, including:

- Searching the literature to determine best practices;
- Learning extensively from the direct experiences of other jurisdictions;
- Consulting various existing public health agencies about their programs and functions;
- Consulting experts on governance in the public sector;
- Conducting roundtable discussions with participants representing a wide variety of expertise, knowledge and experience, including those from Public Health Units, hospitals, community health settings, the voluntary sector and academia; and
- Reviewing the key findings of extensive survey and interview data generated from all 36 Public Health Units and from over 1,300 public health professionals.

Roundtables were convened on:

- Health promotion, chronic disease and injury prevention;
- Infectious diseases; and
- Environmental health.

The outcomes of the three roundtables were consistent and validated the role of the Agency. Roundtable participants envisioned the Agency as playing a central supportive role in their respective fields by:

- Building core technical capacity of relevance to practitioners and professionals in a range of disciplines by:
    - Identifying gaps in capacity and supporting networks of expertise or communities of practice (for example, in epidemiology);
    - Facilitating stronger connections between these communities of practice and the field;
    - Developing online resource tools, training opportunities and continuing education initiatives; and
    - Increasing ease of access to a range ofspecific areas of technical expertise by liaising formally and informally with local, national and international experts;
- Developing links and communication channels to improve and coordinate the sharing of best practice information, data and analytical findings;
- Developing practical tools based on evidence and science; for example, developing specific tools and supports to assist Public Health Units in implementing the Mandatory Health Programs and Services Guidelines (MHPSG)[5];
- Shaping research agendas in both the province and nationally such that public health research, including applied and intervention-based research, is not only undertaken but more effectively translated and disseminated; and
- Providing leadership in partnership development and networking, as well as collaborating provincially, nationally and internationally to:
    - Build technical capacity;
    - Provide improved access to leading-edge scientific and technical support; and
    - Encourage and leverage research in identified areas of need.

This validation was overwhelmingly consistent in terms of pointing out a definite need for the Agency to engage in the areas of specialisation and fulfill the functions that the AITF is recommending.

In addition to the roundtables, the AITF has consulted with a range of health system stakeholders. A Reference Panel was established and has met several times to provide a forum for the AITF to update stakeholders on its activities and to hear a variety of perspectives on a wide range of issues related to the creation of the Agency. (See Appendix 2 for the Terms of Reference for the Reference Panel.)

The feedback and input we have received throughout this process has underscored the need for the Agency as recommended in the Walker Report. At the core of the comments received has been the consistently identified need for a trusted source of scientific and technical guidance that is relevant and focussed on translating

research and evidence into tools, training and supports, geared to health care providers and public health practitioners.

While there are clear areas of excellence, public health practitioners and health care providers often face a series of systemic barriers in accessing support for research and knowledge exchange, namely:

- Weak coordination between multiple producers of work of variable quality in different domains of activity;
- Limited direct relevance for front-line application; and
- Insufficient focus on mechanisms to support the use of evidence through the translation of knowledge into practical tools.

Research and knowledge exchange should be key pillars of the Agency. The AITF established a Research and Knowledge Transfer Sub-Committee, including nationally recognised experts, that has developed recommendations related to the Agency's work in these areas. The Sub-Committee also reports to and supports the work of the CRC. (See Appendix 3 for the Terms of Reference of the Research and Knowledge Transfer Sub-Committee.)

Building on the Successes of Other Jurisdictions

Much can be learned from the successes of other national and international jurisdictions. Many either have in place, or are currently taking steps to establish, more focussed and specialised bodies dedicated to providing technical and scientific public health support. Most recently, the European Union[6] and Hong Kong[7] have moved to create specialised bodies. Countries as diverse as Finland[8] and Brazil[9] have in place specialised public health bodies distinct from their principal health care planning bodies. These bodies range in size from approximately 8,000 employees at the U.S. Centers for Disease Control and Prevention (CDC) through to as few as 70 or 80 employees at smaller organisations. Despite their diversity, what tends to be common among these organisations is a dedicated focus to promoting of research and scientific engagement to enhance the ability of planners and providers to the access to advice, evidence and support for their work.

Two Canadian provinces, Quebec and British Columbia, currently have specialised public health bodies in place. The AITF has also benefited from ongoing advice and lessons learned from discussions with the British Columbia Centre for Disease Control (BCCDC)[10] and the Institut national de santé publique du Québec (INSPQ),[11] as well as from examining the structure and experiences of the CDC[12] and the U.K. Health Protection Agency (HPA) a recently established legislated agency with the specific mandate to "protect health and reduce the impact of various hazards"[13]. The Ontario model being recommended most closely resembles Quebec's model. Figure 1 provides is a representative selection of some specialised public health organisations. At the same time, as we examined other agency models, we were also very aware of the evolving roles of ministries.

Ministry Stewardship

Just as there is an increased focus internationally on specialisation evidenced by the establishment of dedicated centres of health protection and promotion in many jurisdictions, so too, the emphasis on defining an organisation's core business is gradually altering the way many governments are defining their role in health care.

Recently across Canada, greater emphasis is being placed upon defining the role of government in health care in terms of stewardship. This has permeated the language of reform for several years now and is witnessed in the recent reforms proposed for the MOHLTC.

Behind the concept of stewardship is the belief that core government responsibilities include: policy development and analysis, legislation, long-term planning, setting strategic directions, enforcement and accountability for funding and outcomes, and monitoring, reporting and overseeing performance. In addition to devolving aspects of program management to the local planning level, another reform has been to reduce government involvement in direct health care delivery. Much of the Province's work in public health falls clearly into the domain of stewardship and therefore is not the role of an agency.

Effective health protection and promotion efforts, however, rely on a range of activities and supports which fall far less easily into the core definition of stewardship, and, as such, into how Ministries structure and prioritise their functions. Some of the activities and supports that the Agency could provide:

- Generation of research evidence;

A History of Specialized Public Health Organizations Around the Globe

	Quebec Institut national de santé publique du Québec (INSPQ)	**BC** Centre for Disease Control (BCCDC)	**US** Centers for Disease Control and Prevention (CDC	**UK** Health Protection Agency	**Hong Kong** Centre for Health Protection	**EU** European Centre for Disease Prevention and Control
Date of creation	1998	1997	1946	2003	2004	May 2005
Type of Entity	Fully arm's-length Authority derived from special legislation (An Act Respecting Institut National de Santé Publique du Québec, 1998)	Arm's-length (degree) Established as a Society (corporate body) and accountable to the Provincial Health Services Authority – somewhat arm's length	Part of government Part of the Department of Health and Human Services	Fully arm's-length Authority derived from special legislation (*Health Protection Agency Act 2004*)	Part of government Part of Hong Kong's Department of Health (the Controller for the CHP reports to the Director of Health)	Fully arm's-length Authority derived from special legislation (Regulation of the European Parliament and of the Council, 2004)
Mandate	To improve the coordination, development and use of expertise in public health, and to develop knowledge and share information in public health.	To support a comprehensive program of communicable disease and environmental health prevention.	To promote health and quality of life by preventing and controlling disease, injury and disability.	To protect health and reduce the impact of infectious diseases, chemical hazards, poisons and radiation hazards.	To achieve effective prevention and control of diseases in Hong Kong in collaboration with major local and international stakeholders.	To identify, assess and communicate current and emerging threats to human health from infectious diseases (may be broadened to non-infectious diseases after a scheduled review in 2007).
Focus	• Surveillance and population health assessment • Health promotion • Disease and injury prevention • Health protection • Administration of public health laboratories, toxicology centre, provincial audiological and radiological screening service	• Hepatitis services • Epidemiology services • Laboratory services • Sexually transmitted disease/AIDS control • Tuberculosis control • Drug and Food Information Centre • Food protection • Radiation protection	• Health promotion and prevention of disease, injury and disability • Preparedness, including protection from infectious, occupational, environmental and terrorist threats	• Infectious diseases • Chemicals and poisons • Radiation • Emergency response • Local and regional services • Research • Risk communications	• Surveillance and epidemiology • Emergency response and information • Infection control • Program management and professional development • Public health laboratory • Public health services	• Networking public health authorities to foster coordination and collaboration • Linkages with international partners (e.g. World Health Organization, CDC)

Figure 1: A History of Specialised Public Health Organisations around the Globe.

- Development of best practices and decision aids;
- Provision of professional development supports and training;
- Assessment of scientific findings in a wide range of areas;
- Development of effective support tools for program delivery;
- Delivery of distance training and education; and
- Enhancement of outbreak modelling capacity and risk analysis.

These are functions that often fit uneasily into a traditional Ministry structure. However, it is precisely these forms of support that are increasingly needed. Health care provider organisations and public health professionals have consistently reiterated that these types of activities and supports are only partially and inadequately being provided through existing structures. The Task Force believes that by focussing on these types of activities the Agency would both improve the informational supports provided to public health

practitioners and health care providers and increase the availability of public health research to Ministries. This would, in turn, support the core roles of government.

Much of this type of work would involve drawing upon and linking together the knowledge and skills of those working in a range of areas, in Ministries, in the field and in research centres through a structured organisational hub, a role which we see the Agency performing.

By establishing the Agency, the AITF envisions building a more collaborative and consistent approach to enhancing the public health system provincially, and locally or regionally through the generation of tools, advice, training and support across the system. Establishing a dedicated and focussed central resource for public health will also allow for the Agency's partner Ministries to draw upon a more unified and structured scientific base. In addition to the MOHLTC, the new Ministry of Health Promotion (MHP), the Ministry of the Environment (with jurisdiction over water and air safety) and the Ministry of Agriculture, Food and Rural Affairs (with jurisdiction over food safety and elements of animal health) are all logical clients of the Agency. There is a need to further develop our shared understanding and evidence base on human health risks. This would only help leverage more coordinated approaches to anticipating and addressing risks which routinely cross a range of mandates.

The threat of an influenza pandemic from an avian source amply demonstrates just how linked the science and knowledge of human health need to be to our research and understanding of animal health. The proposed approach places great importance on strengthening this link.

Strategic Framework

Defining the Agency's mandate, vision, mission, values and philosophy is key in setting the direction and foundations upon which the Agency will operate. Environmental scans, experience from other jurisdictions, stakeholder consultations, and both formal and informal discussions have contributed to the development of these basic principles, providing the AITF with a strong foundation on which to make recommendations for the Agency. A strategic framework starts with an organisation's vision, mission and values.

Vision

We will be an internationally recognised centre of expertise dedicated to protecting and promoting the health of all Ontarians through the application and advancement of science and knowledge.

Mission

We are accountable to support health care providers, the public health system and partner Ministries in making informed decisions and taking informed action to improve the health and security of all Ontarians through the transparent and timely provision of credible scientific advice and practical tools.

Values

To guide the Agency's mandate, vision and mission, the AITF recommends a set of core values.

Responsiveness

The Agency will meet the needs of its clients across the continuum of the health system by providing timely analysis and practical support by developing and translating applied research, training and advice.

The Agency will have a field response capacity, both in-house and through partnerships, to support, assist and augment local and provincial health system capacity.

Relevance

The Agency will translate research into action-oriented advice and tools for evidence-based public health programs, policies and practices.

The Agency will base its priorities on close consultation with health care providers, Public Health Units and partner Ministries to ensure its services continue to meet current and emerging needs.

Credibility

The Agency will be guided by the best available evidence and science to consistently provide quality information and services in an independent and unbiased manner.

Collaboration

The Agency will build partnerships and will draw upon the best available expertise provincially, nationally and internationally. The multidisciplinary staff of the Agency will respect, support and promote one another's creativity, expertise and well-being.

Innovation

The Agency will be at the forefront o knowledge generation and knowledge exchange in Ontario and beyond. The Agency will provide leadership by being

anticipatory and proactive to threats to, and opportunities for, the health of Ontarians.

Guiding Principles

The AITF spent considerable time looking at guiding principles that should direct and sustain the Agency in carrying out its mandate. The work of the Agency should be guided by a population health approach that supports improving the health of all Ontarians throughout their lives and commits to reducing inequities in health status between population groups.

The AITF recognises that multiple factors, including material and social inequities, contribute to a disparity in health status among populations. Ontario has a diversity of populations including First Nations/Aboriginal communities and francophones. Recognising this diversity in the work and approaches of the Agency would only increase its relevance.

Operational Approach

The AITF has recommended that the Agency adopt a framework to guide its operational approach. Three success factors have been delineated: oustanding people, effective processes, and relevant outcomes. It is against these success factors that the Agency could develop goals, objectives and outcomes.

Outstanding People
VISION
We will be an internationally recognized centre of expertise dedicated to the protection and promotion of the health of all Ontarians through the application and advancement of science and knowledge
Effective Processes
Relevant Outcomes

Figure 2. Operational Approach

Outstanding People: Staffing Philosophy

No matter how well-crafted the organisational design and well-thought out its policies and procedures are, the AITF believes that the Agency will only achieve its goals if it attracts the right people. This will rest in large part on the staffing philosophy adopted by the new organisation.

We are all collectively aware of the many experts in Ontario who currently contribute to scientific or technical panels of international organisations such as the CDC, that many of us in Ontario subsequently seek out as definitive sources of information. In addition, Ontario has seen a number of key leaders in public health leave the system during the period of downloading and instability, to provide valuable guidance and leadership elsewhere.

Clearly, we would envision the Agency changing this dynamic over time, by building an organised cadre of scientific expertise here in Ontario based around the Agency's identified areas of specialisation. By striving to make the Agency a flagship, we would not only increase Ontario's public health profile, but would take clear steps forward in helping to draw expertise to the province, a benefit to both the Agency and the system.

Scientific and technical skills however are not enough. If the Agency only becomes a source of published scientific papers, but is unable to translate this knowledge and evidence into tools and supports that are usable for a public health practitioner, in public health, a nurse in a long-term care facility or a Ministry facing emergent issues and requiring timely and reliable advice, then it will not have achieved its goal. This addresses the need to combine scientific and technical skills with skills in knowledge translation and communication.

The Agency also needs to be grounded and remain relevant to the issues faced at the point of public health and health care delivery. This requirement points to the need for a staffing approach which, for some portion of its staffing, would allow for individuals to maintain their current clinical practice or public health role, while serving on a shared time, rotational or affiliate basis at the Agency.

We believe this approach has merit as it could:

- Partially mitigate against the new Agency permanently drawing scarce resources out of the system by allowing engagements that promote a sharing of capacity between various bodies and organisations;
- Allow for a broader pool of experience to be drawn into the Agency's activities;
- Prevent the Agency from becoming overly academic or otherwise disengaged from front-line work; and
- Reduce the distance between the Agency and the front-line by acting as a two-way conduit between

public health practitioners and health care providers in the field and the Agency itself.

We would also strongly recommend the Agency adopt a progressive approach regarding graduate placements and training positions. Creating new opportunities for people to enter the field is critical for a public health system facing staffing challenges which are at risk of worsening in the years ahead.

Students considering public health as a career often face significant challenges in obtaining public health placements. This limits the pool of those who might choose public health as a career and slows attempts to rebuild the public health workforce. The Task Force believes that the Agency has a responsibility to lead by example and act as a magnet location for placements, thereby influencing and assisting to improve the supply of public health professionals available to the system as a whole.

For the reasons set out above, it is our belief that the Agency should consciously adopt a staffing philosophy that allows and encourages flexible staffing arrangements.

Staffing Mix

Full-Time Staff

To achieve organisational permanence and relevance, and to develop effective working relationships across a range of partners, the Agency needs to create a workplace history and culture. This requires a degree of permanence, continuity and stability at the core of its organisation. As well, a number of core day-to-day operational functions need a sufficient complement of permanent full-time staff in place to succeed.

The AITF recommends that the senior and lead staff in all technical areas be engaged on a full-time basis. In addition, the functioning of the Ontario Public Health Laboratories (OPHL) requires an adequate pool of permanent, full-time support.

Part-Time Staff

To maintain relevance and ensure that the expertise in the Agency remains current, a spectrum of flexible work arrangements should be in place. This concept of a more permeable structure, than in the bureaucratic norm, that would allow those working in the field to maintain their expertise and bring it into the Agency. At the same time, such staff would have access to the Agency's resources, research and cross-disciplinary expertise.

For example, in the area of infection control, an Infection Control Practitioner (ICP) employed part-time at a hospital and part-time in the Agency would enable the ICP to bring to the Agency the realities and issues of day-to-day practice. At the same time, the Agency could provide that individual with access to a multi-disciplinary team engaged in cutting-edge research.

Affiliate Scientists/Researchers

Having scientists or researchers affiliated with the Agency is an effective mechanism used by organisations such as the Institute for Clinical and Evaluative Sciences (ICES) to promote innovative research. This approach would allow an individual to be formally affiliated with the Agency, work on certain core projects on an as needed basis, and at the same time retain their field or academic affiliation and employment. Affiliation should be based on demonstrated expertise or contribution to a specific field.

Cross-Appointments

Researchers and specialists in public health, chronic disease, infection prevention and control and environmental health are first and foremost knowledge workers. People who work in senior levels in these fields often spend much of their lives bridging research practices and field or clinical practices. This reality of current work expectations needs to be reflected in the way in which the Agency designs its staffing framework.

Recruiting high calibre individuals in the future will not simply be about how much they are paid. It will be about how their expectations can be met for a work environment which not only allows, but also supports and fosters, research and practice.

We therefore strongly support the promotion of cross-appointment arrangements through academic affiliation agreements. This approach is used effectively in public health agencies in British Columbia and Quebec, at the CDC, and at the state level in the United States. It also resembles the approach adopted in the UK agency and the Public Health Observatories, as well as approaches pursued by a number of Public Health Units and research centres in Ontario.

The Task Force envisions that, over time, cross-appointments could be used as a mutually beneficial approach to recruiting and retaining skilled staff. For example, a staff member of the Agency could have a cross-appointment for teaching at the University of Toronto and a faculty member of the University of

Waterloo could have a cross-appointment to the Agency to engage in research. This has the added benefit of beginning to break down the silos between academic, policy and practice.

Secondments and Transition

Effective links and knowledge of organisations and institutions will be required in many areas of the Agency's work. It is important to ensure that the Agency is a functional partner and understands the processes and structures of other organisations, with which it will require effective working relationships, such as partner Ministries and Public Health Units. We envision that the Agency's structure will allow for two-way secondments between staff in appropriate areas. This would enable staff from both the Agency and other organisations to bring into the Agency direct experience and take back experience and knowledge gained to their Public Health Unit or faculty. For example, staff from the MHP could take a secondment at the Agency to work on assessing evidence of behavioural interventions to combat obesity together with researchers and field experts.

Training Placements and Professional Development

The Agency should, as we have recommended, act as a training ground for new public health professionals by providing placements for students and others entering the field through an organised placement program.

Project Specific Engagement

We would envision these as time-limited engagements associated with specific projects or initiatives focussed on addressing a short-term or localised need. This would allow staff from a variety of disciplines to work with the Agency while enhancing both the Agency's expertise and depth and level of engagement. Such an approach might be a time-limited project associated in a highly specialised area of expertise, for example, developing best practices in tuberculosis control measures among new immigrant populations.

Standing Advisers on a Retainer

A standing adviser arrangement could be effectively employed to access certain highly specialised skill set that the Agency would require from time to time. The expert would work for the Agency on a retainer and could be called upon as required. The Agency would, for example, likely not require a full-time specialist in the impact of silica exposure. However, on as needed basis, it would need to have the mechanisms in place to access such services to supplement its capacity.

Effective Processes

Priority Setting

In the Part One Report, the Task Force recommended that the Agency develop a three-year rolling Strategic Plan with input generated through priorities identified through two streams.

First, a coordinated mechanism for MOHLTC, MHP and partner Ministries to engage in priority setting is set out in some detail in Chapter 3. Recognising the breadth of public health and the value of cross-Ministry awareness and input into work undertaken by the Agency, the Task Force recommends that the Chief Medical Officer of Health (CMOH) lead the establishment of intra- and inter-Ministry coordinating process. This type of mechanism has been effectively used in Quebec to ensure that the strategic directions of the INSPQ are aligned with the appropriate Ministries in Quebec, in a clear and coordinated manner.

Second, the AITF proposes that a range of mechanisms be built into the planning cycle to ensure clear and planned opportunities for public health practitioners and health care providers to identify areas of need consistent with the mandate of the Agency. Such mechanisms might include:

- Establishing a table of representatives from public health and provider organisations (e.g. Regional Infection Control Networks (RICNs), and the proposed network for research and knowledge exchange) that would come together at appropriate intervals in the Agency's planning cycle in order to convey strategic priorities. The organisations would be responsible for canvassing their members and bringing forward priorities or identified gaps.
- Representatives from each Public Health Unit could come together for roundtables, reference groups and regional feedback sessions to establish the priorities and directions most important for them.

Although it is the ultimate responsibility of the Board to decide on the Agency's Strategic Plan, this Plan will need to have appropriately incorporated into it a balance of priorities identified through the Agency. The process for ensuring adequate input from the field is an important component that can assist the Agency in fulfilling its mandate in a manner that is relevant and practical to those carrying out health protection and promotion in Ontario.

Relevance and Access

The AITF recommends that the Agency not be structured as a virtual organisation, but rather function as a viable, comprehensive infrastructure with a tangible physical presence. The AITF further recommends that the Agency be located in Toronto to provide easy access to the CMOH, and key Ministries.

At the same time, we have consistently adopted the philosophy that the overall approach of the Agency to developing academic partnerships should not be determined by physical proximity to Toronto, but to where centres of expertise and experience relevant to the functions and mandate of the Agency are currently housed. To that end, we would strongly recommend that the Agency retain this philosophy and over time establish the appropriate affiliation and partnership agreements with such centres across the province as the need and opportunity warrants.

We have also spent considerable time trying to work through the best way in which research, knowledge exchange and training could be effectively conducted across a vast geography of diverse needs.

On a very basic level, the AITF acknowledges that the work of the Agency can only benefit from strong capacity at the local level. From a local perspective there is clearly a need to ensure that there is sufficient critical mass with the know-how and skills required to apply research and evidence to policy and practice of local public health delivery. In this regard the outcomes of the Public Health Capacity Review Committee (CRC) and the ensuing actions which may follow to strengthen Public Health Units will be of clear importance to the Agency.

In addition, the AITF is conscious that a number of activities of the Agency would require that it have in place clear coordinated links for the purpose of the delivery of training supports and research and for ensuring that needs and risks are identified early.

In the area of Infectious Diseases (including infection prevention and control), there are clearly emergent opportunities for the Agency to develop effective coordinated linkages that cross the province. The recently established RICNs, organised along Local Health Integration Networks (LHINs) boundaries, draw together public health, acute care, long-term care and community providers around a focussed set of objectives. These are one obvious vehicle that can provide the Agency with both the means to disseminate and deliver work, but also a mechanism by which specific needs and priorities can be directly relayed to the Agency.

In the area of Health Promotion, the AITF in our Part One Report had indicated the need for a comprehensive review of Ontario Health Promotion Resource System (OHPRS) to be undertaken as a necessary pre-condition to better delineate where and how the activities of the Agency could best link with this existing capacity in a manner that was non-duplicative and promoted greater cohesion and access to the types of products and supports currently provided by the OHPRS.

Once this review is completed, we would anticipate that work between the new Agency and the Ministry of Health Promotion would need to be undertaken to determine how best to structure future relationships in this key area.

In the broader area of local or regional approaches to public health research, education and training, we have learned much from the wealth of experience of both the Health Intelligence Unit (HIU) and the Public Health, Research, Education and Development (PHRED) program. The HIU program no longer formally exists and the PHRED program, while nationally recognised for the work it has undertaken, has gone through the challenge of a disconnect between expectations of meeting provincial and regional objectives while being partially dependent on funding from individual municipalities.

Coordinated Networks for Research and Knowledge Exchange

Well coordinated regional efforts are increasingly required to better support the delivery of knowledge translation and training activities in public health, as are currently being developed in infectious disease control.

Clearly, we would see the need for a more cohesive and equitable approach to the knowledge exchange, training and research supports at a regional level. In undertaking this work, we suggest that a process be put in place drawing on experiences of the RICNs, for example, with lead organisations selected against clear criteria which might include:

- Regional representation, involvement and access;
- Multi-disciplinary steering committee;
- Strategic Plan which aligns in key areas with that of the Agency;
- Established academic affiliation agreement; and

- Demonstrated track record in the fields of knowledge exchange, training and research.

Making this sort of transition from the existing approach is not going to be easy or quick. However, change to the status quo is required in order both to harness the available expertise and experience while ensuring that this is made available across the province in a coordinated and equitable manner.

Promoting the establishment of coordinated regional approaches to increasing both the availability and relevance of research on a more equitable basis should be an early area of focus for the Agency working in concert with partners Ministries to achieve this objective.

Collaborative Work

Team-based work and cross-participation should permeate the culture and philosophy of the Agency in its relationship with Ministries and the field. The Task Force supports the Agency promoting team-based work through agreements, while respecting appropriate areas of responsibility.

For example, a physician employed by the Ministry of Labour and a public health physician from the MOHLTC working with others from the field, could, under the approach we are proposing, engage with Agency staff and affiliates in examining the latest research evidence on measures to improve protection of health care personnel in specific circumstances. We would see this form of approach as spanning a range of levels from participation to time-limited secondments.

The roles of the Ministries would be to bring to the team their particular expertise and knowledge in the area, as well as comprehensive knowledge of the legislative and regulatory frameworks that may apply. The legislated responsibilities of Ministries would obviously remain in place. The Agency, in this respect, would act as a scientific bridge and work to provide both Ministries, and ultimately the field, with the best available evidence. This approach is also an important way to develop the effective working relationships that may be required. It is also an effective approach to ensure that the professional development opportunities opened up by having an Agency structure in place are broadly available to the field, Ministries and Agency staff.

Research, Knowledge Exchange and Training

Regional Infection Control Networks

In regions across Ontario, extensive work is underway to develop and implement RICNs. These networks grew out of the recognition for the need to ensure greater coordination and consistency in infection prevention and control within and between sectors. The networks bring together acute care, public health, long term care and community based providers in a formal coordinated manner, organised along LHINs boundaries to identify and improve approaches to awareness, resources, training and support for infection prevention and control.

We would see the Agency, upon its establishment, building upon and linking to the capacity of the networks by providing materials, training and support, and by receiving from the networks both information and identified priority areas for assistance in infectious diseases and infection prevention and control.

Dissemination and Delivery of Knowledge Products

Producing tools, supports and training requires that the Agency use a range of accessible and cost-effective approaches to delivery. The Task Force sees an opportunity to leverage the considerable investments that have already been made by both the provincial and federal governments in information technology and delivery systems, and to the extent possible all efforts should be based on utilising existing systems.

The opportunities are many and include:

- *Telemedicine Services:* Utilising the provincial telemedicine services such as Network North for the delivery of distance training and supports. This approach is increasingly used in a number of disciplines as an effective way of delivering specialised training and technical support to large numbers of health care providers on a cost effective and accessible basis.
- *Public Health Portal*[14]: The Agency should build upon work already undertaken to develop a public health portal for Ontario. In this regard, the provision of webcasts and web-based training and support tools could be a practical early step, one which builds upon investments already made. Webcast training is increasingly used by the CDC as a means to allow practitioners and providers to access international expertise. A good example of the type of value that the Agency could bring is to support the equivalent of 'video-rounds', making available and disseminating through webcasts the latest conferences on topic specific updates. This effective means to increase broad access to top level expertise is currently underused in Ontario.

- *DVD and CD-ROM-based Televisual tools:* An opportunity exists for improving access to training supports in a range of formats. Increasingly DVD and CD-ROM technology is cost effective and allows for providers to obtain high quality training materials and presentations according to their own schedules.

Partnerships

We have no interest in proposing that the Agency unduly duplicate expertise and capacity that currently exists elsewhere, nor do we envision the Agency as functioning in a vacuum. To be most effective, it will need to leverage the capacity, skills and opportunities that exist in a number of networks and organisations both within Ontario and outside. To effectively meet its mandate, the Agency will therefore need to establish formal and informal working partnerships with academia, research bodies, non-governmental organisations and key health organisations (such as Public Health Units).

In its Part One Report, the AITF developed a set of guiding principles upon which partnerships should be based. The principles were developed very much based on advice from others who have grappled with the challenges of creating and living with academic partnerships at centres with comparable mandates in Canada and internationally.

The INSPQ has affiliations and partnerships with a number of academic centres including McGill University and the Universities of Montreal and Laval, as well as with research bodies and non-governmental associations. The BCCDC has a close partnership with the University of British Columbia. The CDC and the UK Public Health Observatories all employ multiple forms of affiliate arrangements with academic centres across their respective institutions.

While the specific types and forms of academic affiliation agreements vary from place to place, typically they often cover the following range of activities.

- Interdisciplinary research agenda or focus of interest and need to both parties;
- Access to established ethics review;
- Database access;
- Academic affiliations for individual Agency staff members;
- Cross appointments for academic researchers into the Agency;
- Placement program or programs for students; and
- Cross-appointments for teaching and professional development.

The demonstrated benefits of formal partnership or affiliation models seem clear for the purposes of recruitment, pursuit of shared areas of research interest, and for:

- Promoting better links between research, policy and practice;
- Leveraging research funding;
- Attracting human resource excellence to the Agency and its partners; and
- Allowing the Agency to provide more effective access to expertise, support and guidance to meet its mandate.

Partnerships are not, however, without potential problems – problems of differing cultures, expectations, and incentive structures. Closing the gap between the needs of health care providers and public health practitioners, Ministries planning programs and the research community is not always a simple task. The best advice we have received is that the Agency should have clear principles of engagement in place before it proceeds with formal academic affiliation agreements, and approach this area, starting gradually based on clearly identified functional requirements.

Starting with first principles, any partnership considered should:

- Align with the Agency's values, mission, vision and critical objectives to enhance its ability to meet its mandate;
- Be governed by an intellectual property policy that will delineate, at the outset, the appropriate sharing and ownership of information and innovation; and
- Meet a set of key principles set out below.

Guiding Principles for the Agency's Partnerships

Clarity

The objective(s) of the partnership will be clear, well-defined and directly aligned with the objectives and strategic priorities of the Agency. Rules governing the partnership should similarly be clear and well-defined.

Credibility

Partner organisations will have a demonstrated track record in contributing to a key area of knowledge and expertise relevant to the Agency's mandate.

Transparency

The purposes of, approaches to, and mechanisms of

entering into partnerships will be transparent and open to the parties concerned.

Focus on Results

Partnership arrangements will include clear and measurable performance expectations with results that are of value to both parties and that are monitored and evaluated accordingly.

Governed by Exit Rules

Partnership arrangements will exist for a clear and defined period of time, be renewable, be based on achieving stipulated objectives and/or results, and have clearly stated terms for both engagement and disengagement.

Practicality

Partnership arrangements will incorporate mechanisms for practical, cost-effective and timely resolution of disputes.

Mutually Beneficial

Partnerships will be structured to ensure they are sustainable with benefits to both parties.

Priorities for Partnerships

The Agency will need to put into place mechanisms in its early phases to determine priorities for partnerships. The AITF recommends that these priority partnerships be driven by the functions that the Agency will require to meet its commitments and deliverables. The AITF suggests the Agency consider the following partnerships in its early stages to better perform and carry out its mandate. While it will ultimately be for the Board to determine the following examples illustrate areas of opportunity.

Data and Information

The Institute for Clinical and Evaluative Studies (ICES)[15], the Canada Institute for Health Information (CIHI)[16] and Statistics Canada[17], Canadian Institutes for Health Research's (CIHR) Institute for Population and Public Health[18], and Cancer Care Ontario (CCO)[19] are just a few examples of critical organisations housing data that the Agency will need access to carry out a range of the analytical functions required to fulfill its mandate. Establishing data access agreements, either centrally through MOHLTC or directly, is a clear early task for the Agency. Over time, however, we would envision the Agency playing a role not simply in using data that is currently available to create a richer capacity for public health analysis – but also in shaping through partnership approaches the data that might be collected nationally and Provincially.

Surveillance and Epidemiology

The Animal Health Laboratory at the University of Guelph collects surveillance data on animal and zoonotic diseases. This data, as has been identified by others, needs to be coordinated among public health, food safety and animal health organisations. With most emerging infectious diseases originating in animal populations, surveillance of this kind is crucial to increasing both our understanding of and ability to anticipate emergent risks. In addition, early in the Agency's operation, partnerships on data agreements will be required with the Ministry of the Environment with regard to data pertinent to environmental and health analysis.

Training and Education

To develop and carry out its professional development mandate, the Agency should consider early partnerships with various organisations and academia. For example, a partnership with the Public Health Units for placement of its public health professionals in the Agency or with medical and public health schools for students interested in the field of public health. Early partnerships to support capacity building in Ontario could include PHAC's Canadian Field Epidemiology Program and the initiatives underway through the PHRED program.

Access to tailored training in specialised areas, for example, zoonoses in public health, might be provided through an Agency partnership with the Ontario Veterinary College to deliver this. In addition, we would see potential for alliance between the Agency and the Ontario Public Health Association to provide training tools on core compentencies. At the same time, the Agency should invest in professional development for its own staff.

Communication

To quickly build its communication capacity, the Agency should examine the opportunities with the Health Communication Unit at the University of Toronto. This partnership could also potentially enhance the Agency's ability to provide knowledge exchange in its start-up phases.

As the Agency builds a partnership structure, it will need to consider how to foster collaboration, build strong networks and adopt an integrated approach that ensures effective communication and response among the various partners, as well as within the Agency.

Types of Partnerships

All of the Agency partnerships need to be governed either by a legally binding contract or mutually agreeable terms of reference. Partnerships will also include institutional level agreements governing such areas as cross-appointments, secondments, employee sharing, and affiliate positions.

By building on existing capacity, the Agency would be in a position earlier in its mandate to offer professional development, training and placement opportunities. This is especially important because of the Agency's desire to deliver tangible results early for public health practitioners and to increase recognition of the public health profession.

Relevant Outcomes

The Agency should be required to have in place performance indicators and outcome measures against which it can be measured and by which it publicly demonstrates accountability to its clients and funders. In developing performance measures for the Agency, we would suggest that both the approaches of the BCCDC and the INSPQ be reviewed. Both set multi-year performance measures with detailed public reports on progress. In addition, we would suggest that four key domains of measurement be examined.

Timeliness

A consistent challenge faced by policy-makers and decision-makers in many levels of health care is needing high-quality material, good evidence or best practice information upon which to ground a decision very quickly, at a pace that is often at odds with the way that academic research is structured and undertaken by many researchers. The Agency will only begin to add value when it starts to close this gap, increasing the timeliness and responsiveness of research to field and Ministry needs. Achieving this goal, however, will be challenging and will bring to the fore the tension between the need for immediacy and the importance of quality. That said, timeliness must be built into the overall performance framework for the organisation. A question for the first Board and CEO is how to structure the Agency to ensure that it can give reliable information quickly and in a useable form.

Usability

There is a need to narrow the gap between the needs identified by Public Health Units and health care providers for practical evidence-based tools and supports and the way in which research and evidence is often made available. Some innovative ways in which the initial results of research can be disseminated quickly to the field include:

- Produce one-page summaries of key findings to-date and their application;
- Develop and refine simple decision algorithms for public health and infection control practitioners;
- Pilot test approaches to conveying scientific information to providers and policymakers; and
- Issue electronic bulletins on research and program developments in other jurisdictions.

The AITF strongly suggests that the Agency put into place outcome measures that track their ability to deliver relevance in the work they produce. It should not be enough simply to list the products produced; critically important will be a focus on knowing that the work is making a difference and that uptake in use is measured.

Reliability

Ontario has the scientific expertise necessary to have an Agency that is respected beyond the boundaries of the Province. To achieve credibility over time, high quality peer-reviewed articles, abstracts and reports will be a required output. To maintain high standards, it will be important for the Agency to have in place an expert review process which draws on leaders in the specific fields of inquiry both inside and outside the Province. One important set of markers and outcomes measures related to this goal is the extent of the use of the Agency's materials, including citations in peer reviewed journals.

Applicability

Equally important is presenting scientific and technical materials and evidence in a form that is usable to providers and policy-makers. To achieve this will require certain specialised skill sets in order to synthesise and analyse scientific findings, data and evidence so that the impact on policy and practice is clear, evident and understandable.

Understanding how scientific or technical guidance can be applied in different settings is also critical if the Agency is to be able to be relevant to providers working in diverse settings.

This means special attention needs to be paid to ensure the form of information presented is sensitive to the differing realities of the various components of the

health care system. This also means that there is a need to structure outputs appropriately, to test and retest the most effective ways to provide information to different audiences.

For example, best practice information on the control of a disease cannot simply be developed for acute care. It will need to be tailored for homecare or long-term care settings and would also need to be written in a manner that is usable for registered practical nurses or personal assistants. The Agency, should have outcome measures that demonstrate its ability to produce accessible and applicable tools and information which are then field tested and evaluated directly with providers in a range of settings.

Chapter 2

Governance and Accountability

Overview

To determine the Agency's proposed governance structure, the AITF consulted with experts in the field, researched principles of good governance for non-profit corporations in a number of jurisdictions and had discussions with a number of key leads for both research and health sector agencies in Ontario and across Canada.

Certain key principles underlie good governance; accountability, transparency, appropriate delineations of roles and responsibilities and not least, a conscious attention and focus on the practice of governance.

The recommended governance model we propose is consistent and aligned with best practice principles set out in the following documents:

- Meeting the Expectations of Canadians: Review of the Governance Framework for Canada's Crown Corporations;[1]
- Public Appointments Processing Guide;[2]
- Agency Establishment and Accountability Directive;[3]
- Corporate Governance Guidelines for Building High Performance Boards;[4]
- Principles for Good Governance in the 21st Century;[5]
- Appointment Guidelines Governing Boards and Other Public Sector Organisations.[6]

Independence

For the Agency to be credible as a non-partisan, non-political provider of scientific and technical advice, the AITF recommends that it be functionally and operationally arms-length from the MOHLTC, in accordance with recommendations in the Walker, Campbell and Naylor Reports[7-9], and as echoed in the commitments made in *Operation Health Protection*[10]. This approach is complementary to the legislative changes undertaken in Ontario post-SARS to clearly provide the CMOH the right to speak independently on matters of public health.

While a greater arms-length role has been widely cited as providing both greater flexibility and allowing for a more focussed approach to the core elements of the Agency's mandate, it does not in itself guarantee good governance. Stressing autonomy is the easier part of the equation; balancing this with effective coordination and strong governance is hard.

The INSPQ, established in 1998 by special purpose legislation that ensconces the mission, governance and functions of the organisation in detail in a statutory expression, provides a good model of walking the fine line between autonomy and coordination.

In addition to the legislative framework, a detailed memorandum of understanding between the INSPQ and the Quebec's Ministry of Health and Social Services exists that clearly delineates a number of roles and responsibilities.

This arrangement has served the INSPQ well in the seven years of its operation, and is the foundation for the respect INSPQ maintains despite major political changes in government and ongoing reform and transitions at the Ministry level in Quebec.

Ontario has learned from other jurisdictions in proposing the structure for the Agency. Unlike experiences in British Columbia and Quebec or indeed the U.S., where these agencies evolved incrementally over many years, Ontario has made a conscious decision to create a health protection and promotion agency with a clear and defined mandate within a specific timeframe. This carries the greater challenge of attempting to introduce a new organisation into a well developed and complex field. It does, however, allow for greater conscious choice to be made at the outset in shaping the new agency.

Special Purpose Legislation

The AITF deliberated on how best to establish the Agency and considered several options, including:

- Special purpose legislation;
- Regulation under the Development Corporations Act[1]; and
- An affiliation agreement with an existing agency or centre.

The AITF strongly recommends that the Agency be created through special purpose legislation as soon as possible. The Agency should be a scheduled operational service agency of the Crown, with formal accountability to the Minister of Health and Long-Term Care who in turn would be accountable to the Legislature for the activities of the Agency.

The AITF recommends that the legislation contain provisions to:

- Allow the Agency to have access to and hold third party funds;
- Put in place a Board that is competency based and independent from government;
- Include a public representative on the Board;
- Allow for the re-deployment of staff in times of emergency and exigent circumstances; and
- Obtain the legal authority required to allow the Agency to collect, use, and disclose personal health information, as well as enable other entities to disclose and share information with the Agency.

Memorandum of Understanding

To enhance accountability and clarity of role definition, the AITF recommends developing a Memorandum of Understanding (MOU) between the Agency and the MOHLTC. The MOU should:

- Clarify in detail the roles, responsibilities, relationships and mutual expectations of the parties;
- Clearly delineate the role of the Agency in support in emergency and exigent circumstances within the Provincial framework;
- Set out in detail the accountability mechanisms, as well as the framework for reporting requirements including the Business Plan, performance measurement and Annual Reports;
- Define the communication mechanisms, protocols and issues management procedures between the MOHLTC and the Agency;
- Lay out the mechanisms and structures for inter-Ministry input (e.g. from the MHP) into the Agency's Strategic Plans;
- Require processes be in place to ensure that the Agency can meet its fiscal responsibilities and mandate;
- Specify the principles and administrative procedures the Agency and all parties should follow; and
- Include the requirement for the Agency to have undertaken periodic third party external reviews of its operations to ensure it is fulfilling its mandate.

Multi-Year Funding

The AITF recommends that the Agency be funded on a multi-year basis. This would provide the Agency with a longer-term approach to planning and resource management. A multi-year funding plan will better allow the Agency to incorporate long term activities that are relevant to the field and the province. Multi-year funding provides predictability, both to the Agency and to the government funder. It also allows for the better alignment of strategic planning and accountability, since the longer timeframe allows funds to be better tied to outcomes and deliverables that take more than one year to realise.

Accountability

As well as enhancing accountability through the instruments mentioned above (legislation, MOU,

multi-year funding), the recommended governance model sets out clear lines of responsibility and clear reporting relationships, building in both audit and governance functions into the structure of the organisation. Every report on public health since SARS has identified organisational autonomy as essential. This is clearly one necessary condition of success. While autonomy carries with it a series of potential benefits in terms of organisational flexibility, responsiveness, and scientific recruitment and retention, it also carries with it risks. Not least of these is the risk of the Agency not discharging its obligations in an accountable and transparent manner. For these reasons, we have focussed on strong governance.

The Chair of the Board is accountable for the functioning of the Agency to the Minister of Health and Long-Term Care, who in turn is accountable to the Legislature for the activities of the Agency. Although the Agency should serve both the field and several Ministries, a single accountable Minister should be in place to answer for the activities of the Agency, thereby providing clarity.

In keeping with good governance principles, an accountability framework with performance indicators should be developed and the Agency be required to report annually on progress against these performance measures.

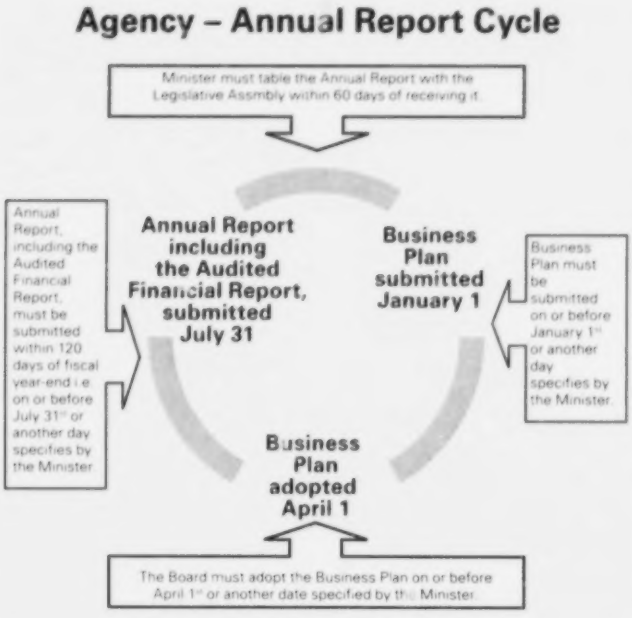

Agency – Annual Report Cycle
Minister must table the Annual Report with the Legislative Assembly within 60 days of receiving it
Annual Report, including the Audited Financial Report, must be submitted within 120 days of fiscal year-end i.e. on or before July 31st or another day specified by the Minister
Annual Report including the Audited Financial Report, submitted July 31
Business Plan submitted January 1
Business Plan must be submitted on or before January 1st or another day specified by the Minister
Business Plan adopted April 1
The Board must adopt the Business Plan on or before April 1st or another date specified by the Minister

Figure 3. The Agency's Annual Report Cycle

Accountability Agreement

Accountability mechanisms for the Agency should include: a Business Plan including a performance plan and an Annual Report. These documents will clearly lay out the goals of the Agency, as well as document the Agency's progress and results and set out time frames for achieving goals. The Minister will be responsible for tabling the Annual Report in the Legislature.

Third-Party Review

The AITF recommends that there be regular third party reviews of the Agency's operations. Given the weaknesses highlighted in reports following the SARS outbreak, the AITF is aware of the need to ensure that the Agency undergo third party reviews on a regular basis. The AITF proposes that these reviews draw upon expertise and be undertaken by expert individuals from comparable agencies and Ministries from within and outside of Ontario, and that the key findings of these reviews should be publicly available.

Transparency

The Agency must have systems and structures in place to ensure there is transparency in applying and complying with internal policies. Stakeholders, government and the public should have the means, via regular reports, of ensuring that the Agency is accountable for delivery of its mandate and activities and is using its resources effectively.

The Strategic Plan of the Agency should bring together the common priorities of the clients and be available to the public. The Strategic Plan should be developed by the Strategic Planning Standing Committee of the Board and take into consideration the gaps, opportunities and priorities of its clients including the Ministries in the government, as well as key priority areas idenstified through engagement with health care providers and Public Health Units.

The Agency's annual Business Plan should lay out the Agency's plan of action, the specific goals that are to be achieved, strategies for achieving the goals, as well as the objectives and performance measures for each goal.

For example, in the area of detecting and responding to new disease threats, strategies or goals may include: strengthening surveillance capacity regarding emergent facility-acquired infections, and building the human resources and expertise required in the field of infectious disease and infection prevention and control. Performance measures for these goals may include:

- Module for continuing education on infectious diseases for public health professionals developed and delivered to a specific number of sites; and
- Educational seminars held in a specific number of locations specifically for family physicians and emergency room personnel on infectious diseases and infection prevention and control.

The governance model recommended by the AITF for the Agency, including reporting relationships, is set out below.

Proposed Governance Structure

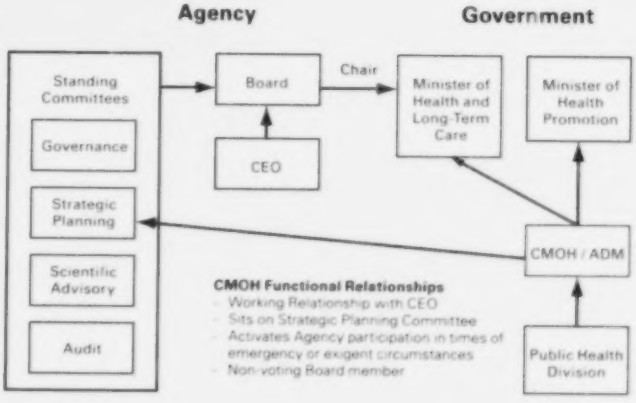


Figure 4. Proposed Governance Structure

Board of Directors

Board Structure and Competencies

Directors of a Board are legally charged with providing the informed strategic stewardship of an organisation. We have learned much from examining the pitfalls and risks that arise from poor or ill-defined governance. It is because of the fact that poor governance so often translates into poor performance that we have spent so much time on this area.

Based on best practices, the AITF recommends that the Board of the Agency be competency-based rather than representational or health-discipline or sector based.

Consistent with affirming support for an appropriately arms-length nature, we also recognise that elected officials and officials sitting as representatives of a specific part of the health sector, a specific health discipline or public health organisation have a distinct duty to their constituencies. Constructing a formal Board on a representational basis is therefore not supported by the AITF as it risks building in from the outset a cluster of blurred affiliations that could impede the focus required to get a new organisation up and running.

The AITF recommended in the Part One Report that the Board be relatively small (seven to thirteen members including the Chair) and members must represent a suitable breadth of skills and competencies; for example, legal, financial, business, scientific and technical, communication and knowledge exchange. The Board should include individuals with public health and broader health sector leadership skills.

The Task Force also suggests that the Board formally invite key PHAC representatives and other provincial public health agencies to Board meetings to foster better linkages between the new organisation and key resources and supports across the country.

The AITF strongly recommends that the founding Board for the Agency of five to seven members be in place by in 2006 to support the timely start-up of the Agency and meet the government's commitment as stated in *Operation Health Protection*. The Board can subsequently be expanded in an incremental fashion, to a full complement of thirteen.

The Agency as an independent non-profit corporation should have the power to establish committees of the Board. In the Part One Report, the AITF recommended that the Standing Committees of the Board include a majority of non-Board members. However, in subsequently reviewing best practices, the AITF noted that it is recommended that Standing Committees of Boards have a majority of Board members on them to ensure that accountability and responsibility of the Committees rests with Board members. The AITF recommends that the composition of the Standing Committees be carefully considered so as to ensure that Board accountability is maintained.

The AITF recommends that the Board establish, at a minimum, the following standing committees:

Audit Committee

This Committee should be charged with:

- Ensuring the fiscal accountability of the Agency is appropriately monitored;
- Reviewing, and recommending for adoption by the Board, the appropriate financial policies and controls for the Agency;

- Functioning as the liaison point for both internal and external auditors;
- Ensuring that the Agency conducts itself according to the principles of ethical financial behaviour and is efficient and responsible in its use of public funds; and
- Identifying and reporting to the Board potential financial risks to the Agency.

Members of this Committee should be transparently independent of management and will need to have financial literacy and suitable skills, abilities and experience in financial risk management.

Governance Committee

In the AITF's Part One Report, the AITF did not include a Governance Committee in its recommendations for Standing Committees of the Board. The Task Force now recognises that supporting effective governance needs to be built into the Agency at the time of its incorporation, not after possible failures occur. The AITF recommends that the Agency establish a Governance Committee to put in place the processes and protocols to ensure maximum Board effectiveness.

Governance involves a distinct skill set that has been identified as a competency for Board members. The Agency's Governance Committee should be exclusively made up of Board members who will be responsible for activities such as:

- Developing and reviewing the Agency's policies and creating by-laws;
- Establishing processes for Board, and Board member, evaluations;
- Setting criteria, benchmarks, goals and performance measures for the CEO and senior management;
- Establishing processes and programs for Board orientation and ongoing education;
- Succession planning for Board members, including maintaining profiles of current and required skills and expertise; and
- Establishing and implementing processes for identifying possible new Board members for consideration.

Strategic Planning Committee

The purpose of this committee should be to advise the Board on the strategic direction of the Agency, including:

- Bringing forward a three-year Strategic Plan to the Board;
- Identifying modifications or adjustments to the plan and bringing them forward expeditiously for resolution;
- Bringing forward to the Board approaches to refine and improve the strategic planning process as a whole; and
- Identifying risks to the organisation in achieving its strategic objectives and recommending to the Board approaches for mitigation.

As a member of this committee, the CMOH would act as a key participant to ensure that the Agency's Strategic Plan is informed by provincially identified priorities and Ministry partners.

This Committee should also provide guidance to the Board on mechanisms to ensure that broad stakeholder input is sought out and taken into consideration. The Committee should be charged with recommending approaches to strengthen and develop regional and local input into the priority setting functions of the Board.

Scientific Advisory Committee

This Committee should be comprised of clinical, academic and public health science experts drawn both from the Board and external to the Board. It will provide scientific and technical advice and be closely linked to the Strategic Planning Committee. This committee should be charged with bringing to the Board:

- Guidance on ensuring scientific consistency and rigour;
- Protocols regarding ethical research practices; and
- Assistance in securing national and international expertise to support peer review of practices, protocols and materials generated by the Agency.

Selection and Appointment of Board Members

Founding Board

In its Part One Report, the AITF recommended a staged approach to developing the Board, in order to have in place some directors with start-up expertise to facilitate the process of launching the organisation.

These founding members are then expected to form the core of the Board by continuing to serve as full Board members. This staged approach, moving from a start-up Board of between five and seven members and expanding to thirteen may minimise delays in getting the Agency up and running while

providing for continuity and stability in Board membership and leadership.

This staged approach would also give the Founding Chair a better opportunity to assess the balance of skill-sets required after a brief period of operation for the Agency and to bring forward suitable candidates to address potential areas of weakness in the Board.

Full Board

As is usual with agents of the Crown, the appointment of Board members should be through Order in Council. The AITF recommends that potential candidates for the Founding Board and the Board Chair be identified through a transparent and non-partisan process led by the AITF co-chairs, appropriate external experts in the field, and a representative from the INSPQ. A long list should be developed from which a short list would be submitted to the Minister of Health and Long-Term Care for review. The clearly defined criteria, including job description and qualifications on which candidates will be assessed, should be publicly available.

To ensure that Board members have the skill sets to meet the changing and evolving needs of the Agency as it grows, the AITF recommends that staggered terms of service for Board members be used. Appointments for some Board members would be for three years while for others it would be two years. All Board members would have the opportunity for one subsequent three-year re-appointment. This plan allows for orderly succession planning, as well as giving Board members the opportunity to develop and move into leadership positions, such as Chair of the Board or of a committee.

Criteria and Competencies of Board Members

The AITF has set out generic competencies that all Board members must demonstrate, as well as specific competencies and skills that should be present on the Board. The AITF has also recommended that a representative of the public be a part of the Board.

Demonstrated generic competencies and skills for Board members include:

- Understanding the principles of good governance;
- Ability to commit time to participate effectively in the governance process;
- Ability to work effectively as a member of a team;
- Effective communication skills; and
- Absence of any conflict of interest that would interfere with participation on the Board.

Demonstrated specific competencies and skills for Board members at the Board aggregate would include:

- Knowledge of organisation, financing, structuring and delivery of public health services/health services;
- Senior level management experience in a complex environment;
- Financial expertise – including financial analysis, forecasting, and budgeting;
- Strategic planning;
- Quality assurance, risk management and performance management;
- Legal skills including an understanding of intellectual property rights and health law;
- Human resource management;
- Expertise with start-up organisations;
- Information systems management;
- Communications and marketing in a government and media/public relations context;
- Academic expertise in scientific, research or education fields; and
- Other specialised technical skills such as expertise in a technical field, environmental health, zoonotic diseases, laboratory medicine or other relevant fields.

Chief Executive Officer

The Chief Executive Officer (CEO) is the operational administrator and leader of the Agency and is accountable to the Board of Directors. The Board should be responsible for selecting and hiring the CEO through a clear and transparent recruitment and selection process, and subsequently for evaluating the performance of the CEO.

The Task Force strongly recommends that the CMOH have a direct role in the selection of the CEO. While reporting to the Board as a whole, the working relationship developed between the CMOH and the CEO will be a significant factor in helping ensure the Agency is able to function smoothly.

The CEO will be responsible for the management and performance of the Agency, as well as for implementing the Strategic Plan and ensuring that performance plans are achieved.

The CEO will provide scientific guidance to the Agency's work. The AITF recommends that an international search be undertaken for candidates for the CEO position.

The AITF also recommends several non-negotiable competencies that must be demonstrated in the CEO:

- Proven track record as a health sector/public health leader;
- Knowledge of broad Ontario health system issues and trends including a knowledge of public health priorities and needs;
- Ability to recruit and retain skilled individuals;
- Organisational leadership;
- Demonstrated ability to effectively function within government and/or with various levels of government;
- Outstanding verbal and written communication skills, as well as motivational and public relation skills; and
- Demonstrated operational experience with evidence of outstanding team development and sensitivity to front-line workers.

The AITF also recommends that the CEO should demonstrate the following competencies:

- Ability to develop, foster and maintain strategic relationships and partnerships with a number of diverse stakeholders including academia, various levels of government, Public Health Units, health service providers and health care organisations, as well as national and international agencies;
- Extensive management experience and knowledge of innovative management methods, approaches and strategies;
- Ability to demonstrate that he/she is not unduly risk-averse;
- Skill as an integrator and mediator of complex issues among diverse stakeholders;
- Demonstrated success in creating a healthy workplace;
- Experience with managing the start-up implementation of an organisation or business;
- Demonstrated integrity and high ethical standards;
- Demonstrated leadership in research; and
- Demonstrated flexibility and ability to adapt to a growing and changing environment.

Role of CMOH in Relationship to the Board

The CMOH must have a role that ensures alignment between Provincially identified objectives and expectations, and Agency priorities. The AITF recommends that the CMOH, by virtue of office, attend and participate at all Board meetings and be a member of the Strategic Planning Committee of the Board. The CMOH membership on the Strategic Planning Standing Committee will ensure that the Agency's Strategic Plan is aligned with the priorities of the partner Ministries.

While the AITF recommends that the model for decision-making for the Board be consensus based, there will be times when items will need to be voted on by the members of the Board. The AITF feels that the CMOH should not be a formal voting Board member for the following reasons:

- If the Agency is accountable and funded through the MOHLTC, it is likely, directly or indirectly, that the CMOH will be the Assistant Deputy Minister (ADM) responsible for decisions potentially affecting the funding of the Agency by the MOHLTC.
- The CMOH would, under the approach proposed in this Report, have the authority to activate redeployment of personnel or resources of the Agency to address emergency and exigent circumstances where required. This is an important and necessary provision, which provides the CMOH with significant authority over the Board in certain circumstances.

In adopting this approach, we have attempted to meet three objectives:

1) Ensuring a defined role for the CMOH in developing the Agency's direction and Strategic Plans;

2) Protecting the integrity of the CMOH's role as an ADM with direct or indirect authority regarding Agency's budget; and

3) Retaining the primary role of the CMOH vis-à-vis the Agency in emergency or exigent circumstances.

The CMOH should also have direct involvement in reviewing a performance plan or agreement between the MOHLTC and the Agency that would align with the Agency's Strategic Plan.

The CMOH could also have the authority, delegated from the Minister, to "contract" with the Agency for specific projects or research through this performance plan or agreement as part of the annual budget process.

Finally,a good day-to-day working relationship among senior management of the Agency (including the CEO), the CMOH and the Public Health Division is essential. The Agency must also work well with other parts of the

MOHLTC and other Ministries on an ongoing and collaborative basis. The need for regular communication and dialogue between governments and public health agencies has been identified as a key success factor by both the BCCDC and the INSPQ.

Chapter 3

Ministry/Inter-Ministry Liaison

The Part One Report articulated the Task Force's recommendations on proposed roles and responsibilities for the Agency and Ministries as lindicated in Figure 5.

We recommend, for the purposes of clear accountability, the Agency has a single formal window coordinated through the MOHLTC for the purpose of receiving Provincially identified strategic priorities. To support this, mechanisms will need to be put in place to ensure that priority setting incorporates input from a range of Ministries with interest and/or relationship to the areas within the Agency's mandate.

The MHP will share a number of important areas of common interest with the Agency. In particular, the Health Promotion, Chronic Disease and Injury Prevention area of the Agency will need to be responsive to those priorities, needs and strategies identified through MHP.

Intra-Ministry Committee

Since, under this model, the MOHLTC would be responsible for communicating the priority areas of work to the Agency, the AITF recommends that the MOHLTC establish an Intra-Ministry Committee to coordinate project identification. This internal Committee could also ensure that the priority areas of work identified for the Agency's Strategic Plan from a Provincial perspective appropriately cross the spectrum of the health care system (e.g. long-term care, community health, primary care, acute care, home care, etc.). This Committee could also work to ensure that projects initiated are suitably consistent with the mandate of the Agency.

The AITF recommends that the Intra-Ministry Committee be established by the CMOH or delegate, thereby ensuring a direct link to MHP. The Committee should meet four times a year and more often when needed and include representatives from the appropriate Divisions of the Ministry.

Inter-Ministry Committee

To effectively coordinate the input and advice of other Ministries that the Agency needs to consider in developing a Three-Year Strategic Plan, the AITF recommends that the MOHLTC establish an Inter-Ministry Committee.

The Inter-Ministry Committee should pool and identify initiatives, projects or programs that are consistent with the Agency's mandate. These would be recommended and prioritised for either Year 1, 2, or 3 of the Agency's Three-Year Strategic Plan.

Roles/Responsibilities	MOHLTC/MHP*	Agency
Policy, Legislative and Regulatory Development	Maintain lead	Inform and contribute by providing scientific and technical advice and identifying emergent risks
Compliance and Accountability	Enforce compliance with the MHPSG[1]	Support MOHLTC/MHP with the provision of research and evidence relevant to maintaining the standards and developing best practices, templates, tools and support to assist with field delivery of MHPSG
Public Health Human Resource Planning, Assessment and Training	Hold overall responsibility for formal public health human resource strategies	Survey and report on public health training gaps Identify and deliver issue specific training and specialised support tools Act as a provider of continuing professional development for public health practitioners, scientists and researchers
Emergency Management	Lead remains with relevant ministries	Available to provide technical and scientific assistance and support to government before, during and after an emergency Provide rapid on-site field support as required and directed
Communications	Lead for general health communication to practitioners, the public and the media	Provide specialised communication to health care providers and Public Health Units. Support on risk communication
Relationship to Public Health Units, Hospitals, Long-Term Care Homes, and Community Health Centres	Lead for funding Public Health Units and other health care facilities	Provide specialised scientific and technical support including field and training support Synthesize best practices, guidelines and practical tools Provide expert advice
Reportable Diseases	Formal reporting remains to Public Health Unit and to MOHLTC	Support trend analysis on available data, developing and updating epidemiological tools Provide, as required, additional epidemiological analysis and interpretation support
Standard Setting	Ministries retain role in standard setting for program delivery	Provide evidence and analysis to assist in the setting of standards

**Note: for MHP some roles currently may not apply (e.g. emergency management).*

Figure 5. Roles and Responsibilities

The AITF proposes that the CMOH would chair the Inter-Ministry Committee and that it should meet four times a year and more often when needed. The Task Force recommends that the Inter-Ministry Committee include the core Ministries of:

- Health and Long-Term Care;
- Health Promotion;
- Agriculture, Food and Rural Affairs;
- Labour;
- Environment; and
- Child and Youth Services.

The activities of these Ministries intersect with those of the Agency's. These core Ministries might be expanded as the Agency's role is established and evolves. In order to ensure that priorities that may emerge from the 14 Local Health Integration Networks (LHINs) are considered, it is recommended that established channels in MOHLTC be used to funnel emerging strategic priorities to the Intra-Ministry Committee.

The CMOH also has a role inside the MOHLTC and the MHP as an ADM. The AITF suggests that with the dual role the CMOH is the logical person to bring forward the priorities identified through the processes set out above.

The CMOH would therefore be well positioned to bring issues back and forth between the MOHLTC and other Ministries and the Agency. However, the AITF recognises that this proposed model introduces additional responsibilities for the CMOH. As such, the AITF recommends that the CMOH should have the capacity to delegate these responsibilities, as appropriate and noted by the asterisks in the following diagram.

Proposed Role for CMOH with Agency

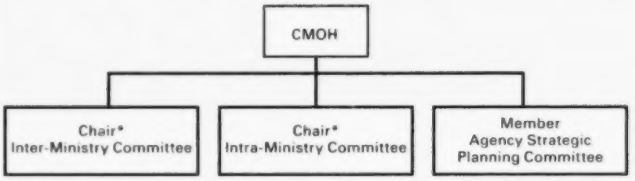


Figure 6. The Role of the CMOH

Ultimately, the Board will approve the Strategic Plan based on the provincial stream of input and field identified priority areas. The Agency should be required to report on its implementation to the MOHLTC.

The AITF recommends that the Agency and the MOHLTC develop formal protocols that clearly delineate how communication takes place between the partner Ministries and the Agency. In particular, the AITF recommends the following kinds of protocols. See Figure 7 to illustrate recommended mechanisms for developing the Agency's Strategic Plan.

Protocols and Coordination

Communication protocols
Communications protocols should be developed between the Agency and the MOHLTC to ensure that both parties are informed and aware of activities, projects and communications in all areas of mutual interest. While this would be agreed to between the first Board Chair and MOHLTC through the MOU process, the principles would apply more broadly than the MOHLTC and could serve as a template for a range of Ministries.

Emergency management support
Much work has been done to outline the role and responsibilities of Ministries in an emergency and the Agency would occupy a clearly defined role within this chain of command. The Agency's role is outlined in Chapter 7. The Task Force recommends that the Agency be a provider of technical and scientific advice and support/response capacity where such assistance is called upon.

Mutual notification requirements
The AITF recommends that there be a framework and process in place for mutual and early notification of emerging issues. For example, if an unusual trend is identified by the MOHLTC, that has relevance to the activities and mandate of the Agency, the obligation would be for early notification to the Agency. A reverse obligation would also be required of the Agency.

Performance and accountability processes
Performance and accountability processes should be established in an MOU, or in formal agreements for projects and initiatives that fall outside the MOU.

Mechanisms for Developing the Agency's Three Year Strategic Plan

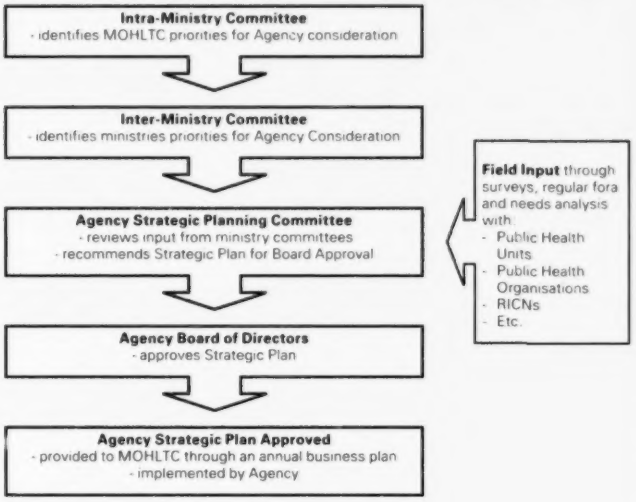

Intra-Ministry Committee
- identifies MOHLTC priorities for Agency consideration
Inter-Ministry Committee
- identifies ministries priorities for Agency Consideration
Agency Strategic Planning Committee
- reviews input from ministry committees
- recommends Strategic Plan for Board Approval
Agency Board of Directors
- approves Strategic Plan
Agency Strategic Plan Approved
- provided to MOHLTC through an annual business plan
- implemented by Agency
Field Input through surveys, regular fora and needs analysis with:
- Public Health Units
- Public Health Organisations
- RICNs
- Etc.

Figure 7. Mechanisms for Developing the Agency's Three Year Strategic Plan

Ministries Sharing Information with the Agency

While formal priority setting should be structured and coordinated, this should not preclude direct working relationships evolving on projects and tasks undertaken between the Agency and the partner Ministry once that priority has been identified. Furthermore, where a specific project arises outside of the agreed to Strategic Plan, the relationship between the Agency and Ministries

should also be structured to allow such projects to be considered with supplemental resources depending upon the nature and scope of the project.

It will also be important that the Ministries and the Agency ensure engagement and information sharing is appropriate, timely and effective. It is anticipated that these processes will need to be reviewed and refined over time. To effectively undertake the analysis and research within its mandate, the Agency will need the authority to enter into a number of agreements with Ministries to allow access to relevant data, for example, the Ministry of the Environment Air Quality Valuation Model that is used to estimate current levels of PM2.5, ozone and precursors.

The Ministry of Agriculture, Food and Rural Affairs undertakes aspects of animal health surveillance including diagnostic surveillance conducted by pathologists and other staff at the Animal Health Laboratory in Guelph. Information from the Animal Health Laboratory could be provided to the Agency for mapping and comparing against information collected from Public Health Units and laboratories for co-relational analysis. This may require modification to the existing procedures regarding release of location information for animal outbreaks, however, the linking of analysis of related human case information would add value and allow for a richer picture to evolve of the relationships between animal and human health. Such enhanced coordination of surveillance strategies was part of a number of recommendations made by Justice Roland Haines in his Report, *Farm to Fork – A Strategy for Meat Safety in Ontario*[2]. Over time, links with the federal databases would be a natural extension of provincial integration of such surveillance data.

The coordination of surveillance databases among public health, food safety and animal health organisations should be encouraged. The Office of the Chief Veterinarian for Ontario was recently created to coordinate animal and food safety incidents or emergencies and link with other key partners, such as the CMOH, who would be valuable partners in assisting in this endeavour.

The Agency's Role in Environmental Health (An Example)

Research on the health impacts of air quality is poorly coordinated and understood.

- Through a partnership with the Ministry of the Environment, the Agency could facilitate ongoing research on air quality by systematically reviewing and assessing existing findings and undertaking scientifically sound and physician-led research on environmental health issues, and use data that links air quality and health to inform surveillance and research approaches provincially and locally.

- The Agency could add value by cross-linking this data with analysis, where feasible, of variations in emergency room use or, over-time the identification of either temporal or geographic trends related to health impact. Based on these results the Agency might then provide advice on refining or updating the form of information that might be considered in smog warnings.

- The Agency could develop consistent evidence-based messages for Public Health Units and health care providers on the interpretation and relevance of Air Quality Index measurements, and recommend to Public Health Units key messages and strategies for getting these messages out effectively.

- The Agency could show leadership and innovation by bringing together and coordinating diverse stakeholders who may not have been involved in environmental issues due to lack of resources or unclear lines of responsibility; for example, in the case of indoor air quality. The Agency would throughout link with specific Ministries whose mandates include environmental health issues.

The Agency's Role in a Widespread Non-Emergency Outbreak of Involving Humans and Animals (An Example)

An outbreak of a previously unknown agent spreads through several communities in Ontario. An animal-borne (zoonotic) disease is suspected.

Before the Outbreak

- Connect surveillance initiatives by public health, food safety, and Animal Health Laboratory (Guelph) and federal surveillance databases to enhance overall surveillance capacity for zoonotic diseases.

During the Outbreak

- Provide ongoing support as required to local outbreak management teams for surveillance, epidemiological analysis, case management and contact tracing, where such support is deemed necessary by the CMOH.

- Facilitate the rapid analysis of specimens to help determine the agent involved in the outbreak through an enhanced and expanded OPHL operating within the Agency.

- Access the Agency's networks of academics, researchers and scientists at various institutions to facilitate data analysis and the development of advice on recommendations for practice during the event. The Agency in this scenario would work jointly with MOHLTC and expertise in the Ontario Ministry of Agriculture, Food and Rural Affairs, the Ontario Veterinary College and others at the University of Guelph, and the federal Laboratory for Food-Borne Zoonoses. The Agency should also ensure that it has in place several veterinarians with public health experience on staff to provide immediate technical support and expertise, and to coordinate these partnerships.

- Liaise and work collaboratively throughout within the overall response framework in place in conjunction with both CMOH, EMU, and appropriate Ministries and Agencies.

After the Outbreak

- Support collaboration among researchers on further research related to this zoonotic agent, coordinating access to data and targeted research.

- Provide the technical expertise to support, enhanced ongoing surveillance and monitoring from afar of the identified agent.

Chapter 4

Organisational Design

The AITF envisions that the Agency's operations will consist of a series of specific *functions* to be carried out within a number of *areas of specialisation* for the Agency's *clients*. Support in Emergency and Exigent Circumstances falls across both the functions and areas of specialisation and is described in a separate section.

Organisational Structure and Rationale

In examining ways to potentially structure the Agency, the AITF considered the need for the Agency's organisation to be flexible and multi-disciplinary with a strong emphasis on the creation of training, professional supports, and knowledge products that could support both the field and relevant Ministries. The Task Force then identified a series of design principles to guide them in proposing an organisational structure for the Agency.

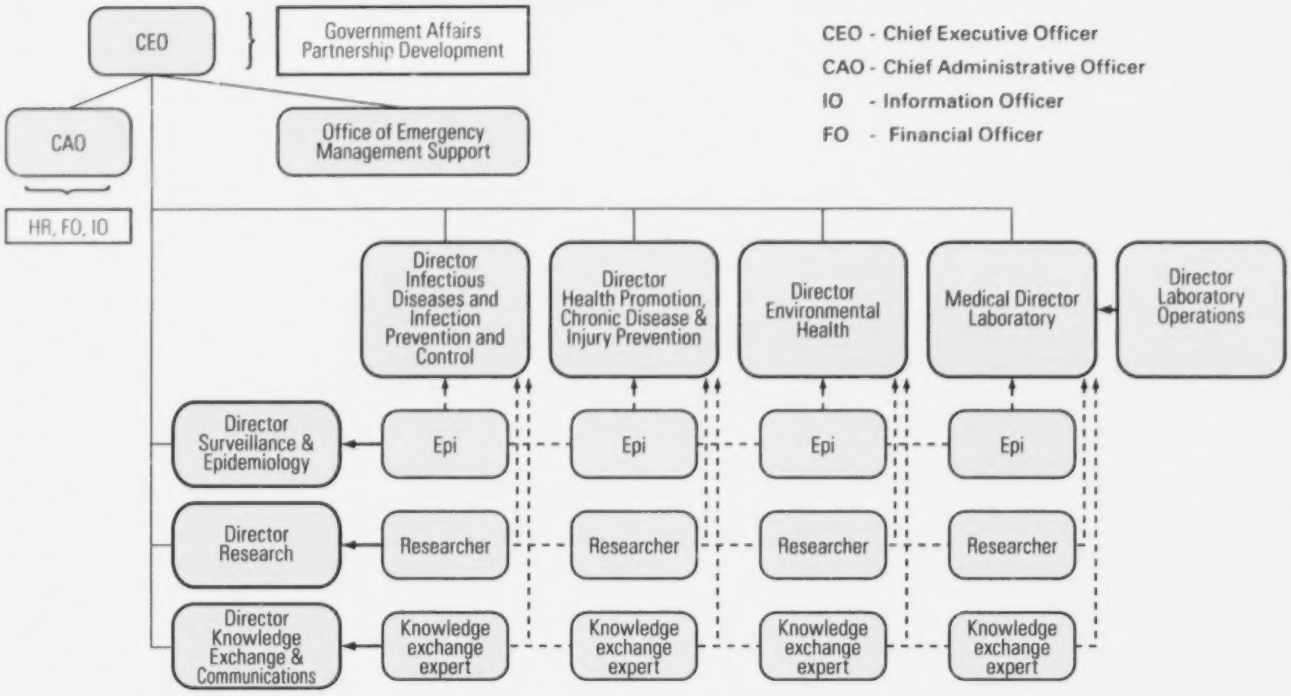
Organisational Principles for the Agency

- The design of the organisational structure should not follow the "silo" approach that is traditional in some organisations. Instead, it should support multi-disciplinary teams (e.g. epidemiologists, toxicologists and health promotion specialists) working across various areas of specialisation.
- The Agency's key functions and areas of specialisation should be immediately identifiable in the organisational structure.
- The Senior Management Team should include both operational and technical skill sets to reflect the spectrum of competencies required to carry out the Agency's mandate.

Organisational Structure

The AITF described the organisational structure only to the levels shown below in the knowledge that the CEO and Senior Management Team that will need to shape the subsequent levels of the organisation based on their history and experience. The proposed structure shows the appropriate expertise and skills required in positions to meet the Agency's priorities, its operational plan for start-up and subsequent phases of development.

Proposed Organisational Design



Solid lines represent direct reporting relationship. Dashed lines represent work allocation.

Figure 8. Organisational Design

Key Areas of Responsibilities

Chief Executive Officer (CEO)

In addition to the traditional areas of responsibility, the AITF recommends that the office of the CEO be structured to carry out the functions of partnership development and governmental affairs.

Chief Administrative Office (CAO)

The AITF recommends that the CAO office be responsible for central services including human resources, legal, financial controllership, internal risk management, information management, and information privacy requirements.

Office of Emergency Management Support (OEMS)

While the number of staff required for this office will be small, this will be an important area of activity for the Agency. The OEMS should be responsible for putting in place processes for emergency management support across the Agency. This office would be responsible for developing the Agency's contingency planning, internal adoption of an Incident Management System (IMS) and project liaison with the EMU at MOHLTC. The Agency's role within the established chain of emergency command is expanded on in Chapter 7 of this Report.

Directors

All directors should be expected to provide professional development, evaluation and peer support to staff who work in the various areas of specialisation and operate both as part of a discipline specific team (e.g. epidemiology team) within specific areas of specialisation (e.g. Infectious Diseases or Environmental Health). These directors should also be accountable for maintaining and developing effective working relationships with counterparts within partner Ministries.

Directors of Infectious Disease and Infection Prevention and Control; Health Promotion, Chronic Disease and Injury Prevention; and Environmental Health

These directors should be responsible for delivering results related to each area of specialisation, as outlined in the first agreed to Strategic Plan for the Agency.

Directors of Surveillance and Epidemiology; Research; and Knowledge Exchange and Communications

These directors would be responsible for delivering the functions in each field of activity and ensuring that the functions are integrated and effectively allocated across all areas of specialisation.

Medical Director of Laboratory Services
This director would be responsible for providing medical and scientific leadership to the laboratories and their staff and for overseeing all medical aspects of laboratory functions.

Director of Laboratory Operations
This director would be responsible for overseeing all operational aspects of the laboratories and for ensuring that operational policies and procedures associated with laboratory functioning are up-to-date, consistent and adhered to and that supplies, equipment and supports are in place.

Rationale for Organisational Design

In designing the recommended structure, the AITF wanted to ensure that the scientists and specialty staff would be supported by peers and that opportunities for professional development and learning were built into the structure.

The Task Force also recognised that staff would need to be integrated into a multi-disciplinary team working within an area of specialisation. This way of working is sometimes referred to as matrix management.

Matrix management can have negative connotations as it represents a dual reporting relationship and the sense that one has to follow 'two masters'. Matrix structures, however, are chosen when an organisation needs staff or areas to integrate effectively across an organisation and provide two or more perspectives at the same time. These perspectives can be related to particular client groups, services, functions, scientific expertise or other considerations.

Having employees with particular skill sets work actively in two different areas within an organisation can also provide flexibility by allowing for greater ability to redeploy resources when specific needs emerge. For example, this form of design for epidemiology services would allow for more effective transfer of additional support across areas, as needs emerged.

This structure also allows for learning opportunities from both the cross-disciplinary team within each area of specialisation, as well as from peers with information and knowledge specific to their particular area of specialisation. For example, an epidemiologist working in environmental health would be part of a cross-disciplinary environmental health team and responsible within that team for doing epidemiological studies and surveillance. He/she would also be part of a peer group of epidemiologists and have a direct reporting relationship to the Director of Surveillance and Epidemiology for professional support and development. This model lets staff interact with other epidemiologists working in other areas of specialisation and allows for cross-fertilisation and information sharing.

The AITF also recognises that the Agency would require an organisational structure that would promote interaction between the more service-oriented functions (e.g. knowledge exchange) with the technical and scientific expertise (e.g. infectious diseases or environmental health).

This approach, we believe, would foster a balance between an individual with specialised content skills (e.g. in emergent infectious diseases or environmental health) and another with skills in knowledge exchange and the translation of technical information to a broader audience. Operationally, if the goal is to be able to take science and render it relevant to the user group, this model of staffing would clearly assist in doing so.

Common Science The Agency would be able to provide a single window of expertise from which various stakeholders and Ministries can obtain evidence-based information and science. This would effectively establish a scientific bridge and horizontal links at a scientific and technical level between existing "silos". For example, the Ministries of Health and Long-Term Care, Environment, Agriculture Food and Rural Affairs, and Natural Resources could all access a common scientific base that they could use for their specialised purposes.

Common Language The Agency would translate science into practical tools and information. This would allow different parts of the health care sector, such as Public Health Units, hospitals, long-term care homes and community-based health care providers, to access trusted scientific information using common definitions.

Communities of Practice The Agency would enhance existing communities of practice and nurture additional ones by supporting collaboration, information exchange and sharing of best practices.

Functions

The functions are the 'how' of Agency operations, the types of services it will provide to its clients in relation to any of the areas of specialisation outlined above. The AITF recommends that the following functions be phased-in and carried out by the Agency.

Figure 9: Functions, Areas of Specialisation and Clients

Surveillance and Epidemiology

"Good surveillance is both the conscience and the compass of an epidemic"

Dr. James Curran Dean, Professor of Epidemiology, Rollins School of Public Health, Emory University.

Coordinated epidemiologic capacity is essential to provide quality data and epidemiologic research methodology to support each of the proposed areas of specialisation of the Agency. The Agency must also have, at maturity, the capacity to carry out specific provincial ongoing or targeted surveillance activities in a technically proficient manner.

Collecting, analysing and disseminating comprehensive, readily comparable data can better inform actions and interventions required in the field, identify emerging trends and threats, allow for richer retrospective analysis and, if undertaken rigorously, would over time better inform the process of setting goals for Ontario's public health system.

The Agency should also provide a mechanism to supplement surveillance activities already underway through Public Health Units or other agencies.

All existing legal reporting requirements for Public Health Units to the Ministry should remain in place through the MOHLTC. The Agency is envisioned as playing a valuable role in undertaking supplemental data analysis and in addition, the Agency should take a lead role in:

- Developing surveillance capacity for facility-acquired infections and non-reportable Antibiotic Resistant Organisms (AROs);
- Enhancing laboratory based surveillance;
- Developing and bridging new and existing surveillance networks dealing with both human and animal health;
- Coordinating cross-sectoral and database links to promote improved information-sharing and retrospective investigation; and
- Working with others to enhance chronic disease surveillance [e.g. Rapid Risk Factor Surveillance System (RRFSS)].

The Agency's capacity to undertake advanced planning would be greatly enhanced by the above surveillance activities. In addition, these activities would support outbreak and scenario modelling, focussed population risk analysis and the development of tools for knowledge exchange.

The Agency could assume a leadership role in identifying and assessing emergent non-traditional surveillance approaches such as syndromic surveillance[3].

Epidemiology is the study of the distribution and determinants of health-related-states and events in populations and the application of this study to the control of health problems.[2]

Health surveillance entails the tracking and forecasting of any health event or health determinant through the continuous collection of high-quality data, the integration, analysis and interpretation of this data into surveillance products (e.g. reports, advisories, warnings) and the dissemination of the surveillance products to those who need to know.[3]

[3] The term 'syndromic surveillance' applies to surveillance using health-related data that precede diagnosis and signal a sufficient probability of a case or an outbreak to warrant further public health response (CDC, Division of Public Health Surveillance and Informatics).

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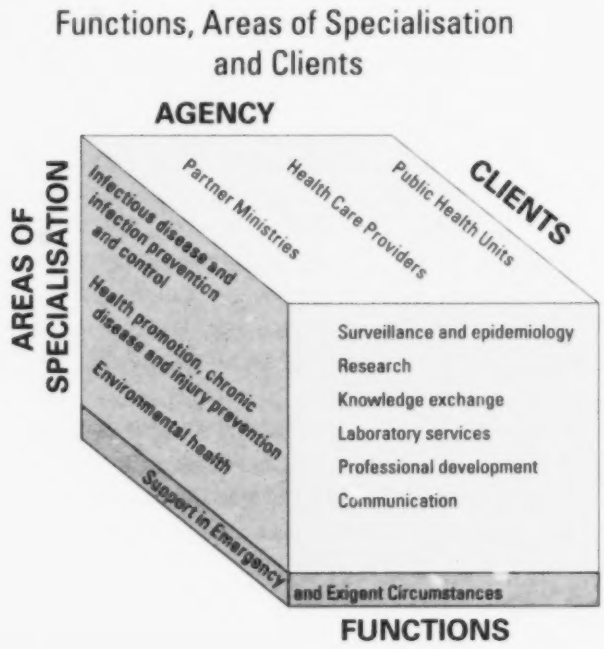

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The Agency is not envisioned as replacing current epidemiologic and surveillance capacity in place locally or centrally but providing a vehicle for addressing areas of epidemiology and surveillance activities which are currently under-addressed, such as:

- Surveillance in areas in which there is a need for greater coverage (e.g. chronic disease risk factor surveillance);
- Attention on areas of emerging risk for which current data capture is inconsistent, such as antibiotic resistant organisms and nosocomial infection surveillance; and
- Specific attention to improving the linkages between animal health surveillance and human health.

We would also see value in the Agency promoting greater cohesion by undertaking standardised indicator development thereby improving consistency of data collection.

The Agency would also be well positioned to provide quality data products to assist in determining the burden of certain diseases in Ontario. This could specifically include undertaking population health and geographic risk profiles with appropriate trend analysis. The Agency could be well placed to draw on multiple data sets to better assess the impact of selected risk factors on disease, and generate and support research associated with these factors. In undertaking this, we would see clear need to establish effective linkages with existing initiatives both nationally and here in Ontario.

In addition to the skills and human resource capacity required to provide a surveillance and epidemiology function within the Agency, the technological infrastructure would need to be in place to allow the Agency, the field and partner Ministries, laboratories and others in the field to share information and have access to common databases in a privacy sensitive manner. Later in the report, we provide a range of suggested approaches to achieving this goal.

Research

Ontario has a history of research strength and expertise in public health. However, the AITF believes that the Agency could, over time, act as a vehicle for better aligning research undertaken in various centres, and augmenting and fostering research excellence in a number of ways:

- By playing a facilitative role in providing coordinated access centrally to relevant research underway both at the Agency and beyond;
- By playing a primary role in defining and promoting an agreed upon research agenda for public health in the Province;
- By adopting an effective review and assessment process with the goal of greater consistency in the quality of research that is disseminated; and
- By drawing upon its knowledge translation and exchange functions to make research products more relevant to users. This would mean consciously focussing on providing research findings that are accessible, understandable and practical for the field and policy makers.

The AITF endorses the view of the Research and Knowledge Transfer Sub-Committee that the Agency's research needs to be tied to knowledge exchange endeavours. This is consistent with the roundtable findings where participants indicated that the key research roles for the Agency should include:

- Promoting a system-wide and cross-sectoral integration of research, policy and practice; and
- Maximising applied public health research capacity.

Through partnerships with academia, Public Health Units, academic health sciences centres, veterinary medicine centres and others, the Agency should serve as the organisational hub for a provincial public health research infrastructure and bring greater leadership, coherence, consistency and relevance to the research agenda.

Given the mandate of the five current PHREDs with respect to public health research, knowledge synthesis, education, dissemination and diffusion, the Agency should partner with the PHREDs as currently structured and subsequently work with MOHLTC to enhance province-wide access to knowledge exchange, training and public health research through the network model outlined earlier in this Report.

In addition, the Agency would be well placed to facilitate a process for identifying and focussing research priorities, as well as assist in filling research gaps, both provincially and nationally based on identified needs.

The Agency should also conduct and facilitate outcome-directed public health research by:

- Focussing on applied research that will inform health policy and front-line practice including:
    - High quality evaluations of public health interventions;

    - Research on effective strategies to support knowledge exchange; and
- Building capacity and strengthening links with health care providers, public health practitioners and policy-makers by providing research mentorship and learning opportunities for both graduate students and field staff.

While the Agency should have strong relationships with research funding bodies, the AITF does not believe that the Agency should be a granting body for external investigator-initiated research This role is already filled by a number of national and provincial organisations and the Agency should not duplicate this function.

Knowledge Exchange

Considerable knowledge generation and synthesis is currently being carried out in Ontario, but often in a fragmented manner which is not always easy to access or well-coordinated.

A large portion of public health publications can also be classified as grey literature, and as yet there is no comprehensive repository for these materials in Ontario and for much research undertaken, no single point of access at the present time. Much valuable work is, therefore, funded and undertaken, yet, remains unseen and unused beyond very narrow boundaries. This results in both duplication of effort and lack of uptake of new knowledge.

In its role as a knowledge broker, the Agency should facilitate improved access to the best available evidence in a relevant and timely manner that takes into account local circumstances and knowledge.

The Agency should also have a role both in generating new action-oriented knowledge, stemming from applied research and surveillance activities, and in synthesising and translating existing knowledge through processes such as systematic literature reviews, advisory expert panels, and the development of best practices, guidelines and consensus statements.

Participants at the roundtable discussions identified the development of provincially applicable best practices, guidelines and protocols that can be tailored to meet specific local needs as an early accomplishment for the Agency and an action that could promote greater consistency in approaches to key issues at a local level.

Library and Information Technology Supports

An effective knowledge exchange function requires an equally strong information technology infrastructure and communications capacity to support it. Research and knowledge exchange will not be efficient or successful without quick access to current scientific information and resources for all staff and affiliates.

The AITF therefore feels that having effective library and information retrieval services in place that are modern and effective in both electronic and print form built into the organisational structure of the Agency from the outset will assist in all areas of the Agency's work, particularly in the central knowledge exchange function.

The Agency's library can also play a role in facilitating access to relevant information not only to the Agency's staff but to Public Health Units, partner Ministries and other client groups.

This function is also envisioned as providing a technical quality check on ensuring appropriate references in technical documents, intellectual property oversight, copyright management, and dissemination and classification of reports and documents.

Laboratory Services

The AITF feels strongly that strengthening the linkages between the laboratory and clinical, research and public health expertise is essential to ensuring a well coordinated and effective interface between the laboratory testing and research functions with the broader epidemiology and surveillance functions required to ensure that the Agency can meet its mandate. Research, knowledge exchange and surveillance functions often cannot be effectively accomplished without direct access to and links with laboratory data. This area of focus is discussed in more detail in Chapter 6 later in this Report.

Professional Development

The AITF sees professional development as a function of the Agency. Training support potentially could be made available to providers and practitioners from various disciplines on a range of topics. For example, this might include professional development for communicable disease control staff from Public Health Units on infection prevention and control in acute care and long-term care settings. Approaches such as this can only complement the work underway to strengthen the working relationships in this area across and between

sectors. Discipline specific sessions might, for example, include epidemiologists at working sessions on non-traditional forms of surveillance.

We do not envision that the Agency will be engaged in the formal education and training of health care professionals. It would, however, assist in addressing two challenges we currently face: a) the shortage of placements for those wishing to pursue public health as a career, and b) the need for strengthened continuing education initiatives for front-line health care providers and public health practitioners.

With these placements and professional development activities, the Agency would also be a benefit from an ongoing and direct link to the needs of those in training, and those working in front-line health care and public health. This can only help ground the work of the Agency.

Communications

The roles of the Ministries and the Agency in communication should be clearly delineated and set out in the MOU with the obligation of mutual notification agreed to by each party. The Agency's role should be to develop effective mechanisms of conveying information to its primary clients and not upon public communications campaigns. That is not to say that the Agency should be invisible to the public; rather, the orientation of its work should be to serve the public primarily indirectly, through science, research and technical support to the field and partner Ministries.

The AITF sees the Agency as having a role in two types of communication. First, the Agency should have a role in developing risk communication expertise. Risk communication exchanges information among concerned stakeholders about an actual or perceived risk from a behaviour or an exposure; for example, exchanging information about the expected type of outcome, its intensity and duration, and what is known about it. Risk communication should come from a trusted and credible source and be validated by other trusted and credible sources.

Effective risk communication helps people make choices about taking a particular action or about adjusting to something that is happening or has already happened[a]. Given its anticipated capacity in surveillance, research and knowledge exchange, the Agency would be well positioned to provide credible scientific and technical expertise to inform and support risk communication activities.

Second, the Agency should be structured to assume a supportive role in crisis communication in times where that support may be requested or directed through the overall Provincial emergency management support framework. Crisis communication aims to de-escalate an emergency through effective dissemination of information. Within the Agency, this role should be integrated into an overall response plan in an IMS structure and operating within the Provincial emergency framework.

The Agency's role in crisis communication would also be in the form of scientific and technical advice to the MOHLTC which would have a key role in crisis communication during an emergency or exigent circumstance with health sector implications. The MOHLTC could also delegate certain crisis communication support functions to key individuals or experts within the Agency as required in the specific circumstances of the event.

Support in Emergency and Exigent Circumstances

The AITF feels that support in emergency and exigent circumstances is both a function and an area of specialisation of the Agency. Best practices in emergency management aim to reduce the potential impact of a disaster by making long-term plans to mitigate negative consequences and improve preparedness. Emergency management activities take place at three stages: before, during and after the emergency[b].

The AITF recommends that the Agency play a supporting role in emergency management within a defined provincial and Ministry command structure. During a health-related emergency, the chain of command should follow a well-defined IMS structure with clear pre-determined roles and responsibilities, while leadership rests with the formally designated authority. Proposed roles for the Agency in supporting response to emergency and exigent circumstances are spelled out in Chapter 7.

Areas of Specialisation

The AITF recommends the following areas of expertise for the Agency's operations.

[a] See also National Framework for Health Emergency Management, F/P/T Network on Emergency Preparedness and Response, 2004.

Infectious Diseases and Infection Prevention and Control

The Final Report of the Walker Panel pointed to the need for a centralised resource to better anchor and support a more comprehensive and systematic approach to infectious diseases in Ontario[5] across different parts of the health care system (e.g. public health, long-term care, acute care). This position is also reflected in *Operation Health Protection*,[6] reiterated in the recent report on the Legionnaire's disease outbreak in Toronto[7] and the CMOH's Report to the Legislature[8], and fully supported by the AITF. The Agency's area of expertise in infectious diseases and infection prevention and control would encompass surveillance, and support improved prevention and control of these diseases and other epidemiologically significant organisms in both health care and community settings through technical guidance, training and support.

Significant improvements have recently been made to the infectious disease landscape in Ontario but much more needs to be done. The Provincial Infectious Diseases Advisory Committee (PIDAC) was established in June 2004 as part of the commitments under *Operation Health Protection*, to be an advisory body to Ontario's CMOH on the surveillance, prevention and control of infectious diseases and facility-acquired infections. PIDAC brings together experts from areas of health care that have not traditionally worked together consistently such as pre-hospital care, acute care, long-term care, Public Health Units, and academia and animal health. PIDAC is comprised of a main committee and four sub-committees:

- Infection Prevention and Control (across the health care continuum);
- Surveillance;
- Communicable Diseases (including infection prevention and control in community-based non health care settings); and
- Immunisation.

Each sub-committee makes evidence-based expert recommendations in multiple areas including:

- Standards, guidelines and best practices;
- Benchmarks and core indicators;
- Research priorities;
- Epidemiologic and surveillance activities; and
- Support in infectious disease outbreaks as requested through the CMOH.

PIDAC and the Agency

The extensive work that has been carried out by PIDAC has been accomplished first and foremost through the volunteer commitment of leading experts in the fields of infectious diseases and infection prevention and control drawn from a wide geographic area.

The voluntary nature of the Committee always raises the possibility that, in a crisis, individuals will have competing commitments between their home organisations and PIDAC. As a result, we see a need to broaden the areas of expertise (e.g. linkages to occupational health research) and move toward a less volunteer and more stable structure to support needs in the area of infection prevention and control. As such, the AITF recommends transferring, over time, the responsibility for the support of PIDAC to the Agency while retaining formal Ministry involvement and connection. We would see PIDAC's composition and structures as evolving and serving as one important source of expertise with which the Agency could formally engage.

The Agency's flexible staffing arrangements (e.g. cross-appointments for experts in infectious diseases) and its research and dissemination functions would ensure that necessary human resources are available in a stable and consistent manner. Establishing and formalising expert working groups is a way that the Agency could efficiently build breadth and expertise in any of its areas of specialisation (e.g. Environmental Health).

The MOHLTC is also in the process of implementing Regional Infection Control Networks (RICNs) dedicated to infection prevention and control. The first networks have been established. The mandate of these regional networks is to maximise coordination and integration of activities related to the prevention, surveillance and control of infectious disease across the health care continuum on a regional basis.

The role of the RICNs in promoting greater consistency and cross-sectoral coordination fits well with the philosophy of the Agency. Therefore, the AITF recommends that there should be clear links established between the RICNs once fully operational and the Agency as set out in Dr. Naylor's and Dr. Walker's recommendations. The proposed formal linkages with the RICNs to facilitate knowledge exchange are one way to assist in ensuring that the Agency remains connected to field relevant issues in prevention and control across the health care continuum and throughout Ontario.

There is also a well identified need for improving access to evidence-based education in infection prevention and control for all front-line health care providers and for those in community settings where procedures that may be high risk (e.g. tattooing, piercing, electrolysis, etc.) are being carried out. The goal should be to provide standardised, evidence-based and easily accessible infection prevention and control training tools for front-line health care providers based on core competencies. Given the proposed mandate of the Agency in knowledge exchange, the AITF feels that the Agency could play a significant role in initiatives such as these.

Professional Development

The Agency would also be well positioned to support and enhance ongoing professional development in infectious diseases, including infection prevention and control, is provided. It should play a coordinating role in ensuring that this is disseminated through colleges, universities, regulated health professionals' organisations and the community.

Health Promotion, Chronic Disease and Injury Prevention

Health Promotion

Health promotion is a public health strategy distinct from disease prevention and health protection strategies. Health promotion begins with the positive concept of health, recognising that health is about much more than 'a lack of illness'. A key component of health promotion is the recognition that being in control or empowered promotes and supports individual and community health. Health promotion strategies range from interventions to influence individuals' decisions about lifestyles or behaviour (for example, counselling or education campaigns about tobacco use, healthy eating, and physical activity) to advocacy, policy and legislative work to affect the social environment in which individual decisions are made (for example, municipal zoning decisions affecting access to trails or green space).

The scope of health promotion work is extremely broad and spans the lifecycle, including maternal and child health, healthy growth and development, youth and teens, adults and seniors. Effective health promotion initiatives partner with diverse sectors and occur in many settings such as workplaces, schools, clinics and community-based organisations. The outcomes of effective health promotion interventions extend beyond reducing disease and ill health to positive states such as

The Agency's Role in Nosocomial Infections (An Example)

Rates of nosocomial infections seem to be rising in recent years. While there are protocols and legislative requirements for the reporting and tracking of certain infectious diseases, many are not required to be reported. As such, research on their occurrence and transmission is often difficult.

The Agency has an important role to play in closing this gap by providing surveillance and tracking of nosocomial infections. This surveillance and epidemiological analysis would help to inform researchers in the Agency as well as in the field to be able to better understand the causes and spread of nosocomial infections as well as determine why some people are more susceptible to these infections than others.

The Agency would synthesise and analyse the research findings along with new and existing epidemiological data and disseminate key findings of early research to appropriate Ministries, Public Health Units, health care providers and other key stakeholders in the field in order for them to develop policy recommendations specific for their needs.

Working with the field, the Agency could develop guidelines on infection control ensuring that these are practical and tailored to specific health care settings (e.g. acute, home care, long-term care etc.). The Agency would take a lead in disseminating these guidelines, but also accompanying this with appropriate area specific training supports through electronic and other means. The Agency should also work with continuing education experts for professional and allied health workers to develop and deliver continuing education modules through distance learning, on-site demonstrations and train-the-trainer initiatives.

healthy growth and development, healthy sexuality and supportive environments.

The Ministry of Health Promotion was recently created to highlight the importance of a health promotion and population health approach. The MHP has developed a strategic approach and delineated priorities.

The CMOH has a dual reporting relationship and serves as the ADM of MHP. While the Agency would be accountable to the MOHLTC, processes and mechanisms should be in place to ensure that the MHP's plans and priorities are taken into account in the strategic planning of the Agency.

There will be no absence of work in health promotion for the Agency to undertake in its first three years. The critical challenge will be determining priority areas of engagement and defining the most effective relationship between the Agency and the complex web of bodies at different levels engaged in health promotion activities. To help inform the new Agency in refining and prioritising operational alignments, we had strongly recommended in our Part One Report, that a detailed review be undertaken of current and potential future roles of the Ontario Health Promotion Resource System (OHPRS). This work is needed and timely not simply for defining working relationships, but also for the Province to have a more holistic and coordinated approach to this important area of activity. From the perspective of the AITF, however, the following are important early contributions that the Agency could make:

- Increase awareness and access to the best of the research evidence already developed through a coordinated scan of resources available;
- Promoting research emphasis on shared risk factors which cut across a range of chronic diseases and conditions;
- Develop mechanisms for grading or ranking available evidence based on a level of evidence framework, where appropriate, and peer assessment, where not applicable;
- Facilitate greater coordination and priority setting in core areas of future research;
- Develop a specialised capacity in behavioural analysis, research and social marketing. This would enhance access at the Provincial and local levels to expert supports in campaign and intervention design and increase capacity to employ effective strategies to change behaviour;
- Undertake evaluations of health promotion initiatives and disseminate findings pertaining to them, including an emphasis on longitudinal impact research;
- Improve the centralised availability of key population health indicators drawn from key national and provincial surveys and data holdings and break this information out to allow for trend, geographic, and population-based analysis by Public Health Units; and
- Undertaking by Year 3 a comprehensive health status report.

Chronic Disease and Injury Prevention

Chronic diseases are the leading cause of death and disability in Canada. In Ontario, the estimated burden of illness from from cardiovascular and respiratory disease, cancer, and musculoskeletal, endocrine, neurological and psychiatric disorders amounts to 55% of total health care expenditures.[9] Further, there are many indirect costs associated with chronic diseases such as those incurred by families. Given this burden, chronic diseases should be one of the Agency's key areas of specialisation.

Preventable injuries, such as falls, motor vehicle accidents, drowning, pedestrian injuries, poisoning and fire, have also become an increasing threat to health. The annual cost of these unintentional injuries is estimated to be $2.9 billion in Ontario.[10] Injury prevention should therefore be a key area of specialisation for the Agency.

Operation Health Protection commits to incorporating health promotion together with chronic disease and injury prevention, as part of the Agency's work beginning in its first year of operation.[11] The AITF deliberated extensively on whether health promotion should form part of a distinct area of specialisation, or whether it should be a strategy that is part of all of the Agency's activities. However, not including it as an area of specialisation may result in health promotion being "lost," particularly in light of other jurisdictions' difficulties in trying to incorporate health promotion into their mandate. For example, the BCCDC has faced numerous challenges in trying to incorporate heath promotion as part of its mandate in recent years.

Ontario has significant capacity in the areas of health promotion, chronic disease and injury prevention. At the provincial level, with the support of the MOHLTC and the MHP, the OHPRS[12] supports practitioners by building capacity, through the provision of training, consultation, resources (print and electronic), network-building

opportunities and referrals. A number of health and disease-specific non-governmental organisations are also major players in these areas and offer a range of opportunities for building on work to date to promote greater coherence and a common centralising focus.

Despite this existing capacity and expertise, there is a need for Public Health Units and partner Ministries to harness the best independent evidence available in the areas of health promotion, chronic disease and injury prevention and translate into useful tools and practical information for evidence-based practice and policy. Roundtable participants who brought forward their perspectives to the Task Force identified a clear need for stronger centralised support in non-communicable disease and risk factor surveillance. In this area, the AITF suggests there is clearly a valuable role for the Agency in working with others to enhance the existing RRFSS and, over time, to consolidate a range of available data sets to have in place a comprehensive central capacity to measure and assess our ability to modify risk factors through public health and related interventions. As a central resource, we suggest that the Agency first focus on enhancing coordination and improving access by building on existing resources in the field. As such, the review of the OHPRS will be instrumental in guiding the future work required to align its role in health promotion with that of the MHP, the MOHLTC and the Agency.

Environmental Health

Chemical, physical and biological factors have great impacts on human health. Attention to these factors in our water, food and air is of paramount importance in preventing a range of communicable and non-communicable diseases and in promoting health and well-being. Environmental health issues became top of mind following the province's recent experiences with the breakdown of safe water and food systems.

In addition, there is a growing demand for specialised capacity within the public health sector to respond to existing and emerging environmental issues[13] and to respond to an increasing array of concerns associated with environmental factors of disease, such as suspected cancer-causing agents with, for example, many forms of breast cancer. Although environmental health was not addressed in the Walker Report nor committed to in *Operation Health Protection*, the AITF sees environmental health as an important area of specialisation for the Agency.

Public Health Units have been involved in food issues for many years, and more recently has begun to address broader environmental health issues, particularly those related to air and water. These endeavours, although not carried out consistently throughout the province, have been critical in developing and establishing initiatives to support local and regional environmental health priorities and needs.

Environmental health focusses on complex problems and requires the contributions of many specialties and areas of expertise. Working collaboratively with other players in environmental health such as the MHP, the Ministry of the Environment, the Ministry of Agriculture, Food and Rural Affairs, and Public Health Units, the Agency could be a hub for resources to support environmental health, research and science. The Agency would also be well positioned to develop surveillance and information management capacity related to such areas as environmental issue identification and the effectiveness of various prevention, mitigation, and control strategies.

Creating an area of specialisation in Environmental Health would allow the Agency to:

- Direct research to support more evidenced-based decision making in what is a developing area of focus;
- Help Ontario anticipate and prepare for emerging environmental health challenges;
- Provide researchers with the ability to link environmental health knowledge and evidence with other fields such as genomics, urban planning and ecology; and
- Provide access to established and evolving centres of environmental health expertise in Ontario and beyond (e.g. the newly formed NCC in Environmental Health housed at the BCCDC).

The Agency would also act as a source of scientific and technical expertise to inform such things as a much-needed program standard for environmental health within the MHPSG[14] and the development of tools and methods for risk assessment and evaluation related to environmental hazards and associated effects on health.

Clients

Clients represent the direct beneficiaries of the Agency's work: the people and organisations for which the Agency should provide its services. In keeping with the

recommended mandate of the Agency, its clients should include the health sector in the broadest sense. To this end, the AITF believes that the Agency's main clients should be as follows:

- Health care providers, including clinicians, public health professionals, academics, health care facilities and institutions, including hospitals, long-term care facilities, community clinics and health centres;
- Public Health Units; and
- Partner Ministries.

Although the Ontario public will not be a direct client, the public would be served by the Agency through publicly available information posted on the Agency's website and, perhaps more importantly, through strengthened support and assistance available to practitioners.

Chapter 5

Legislative Authority

Legal Framework

Currently, the *Health Promotion and Protection Act* (HPPA)[1] spells out the duties and responsibilities of Boards of Health. The Act also delineates the reporting requirements of multiple bodies to the Medical Officers of Health (MOHs) and from the Public Health Unit to the Ministry.

Justice Campbell has, in the *Second Interim Report of the SARS Commission*[2], undertaken an extremely detailed and thorough review of the HPPA, from which he has outlined a comprehensive set of proposed changes to modernise and strengthen this legislation and in particular the powers held by both MOHs and the CMOH.

Parallel to the ongoing work of Justice Campbell, the CRC is currently examining the structure, governance and organisation of Public Health Units. At this stage, it is not known what the final recommendations of the CRC will be. However, given the nature of the topics that the CRC has been addressing, it is clearly possible that legislative changes may be proposed to the HPPA. We do not therefore anticipate that the legal roles and expectations within the public health system will remain static in the coming years. On a matter as central as formal reporting of infectious diseases, however, there needs to be absolute clarity and certainty, particularly once the Agency comes into being.

The backdrop to our thinking on the legislative authority for the Agency is therefore one of anticipated legislative changes. However, we are not yet in a position to determine the exact form that these reforms might take at the central or local level.

Clearly, if our goal is to create a more coherent and aligned system then any final determination of powers and reporting obligations associated with the Agency would need to be undertaken and understood as part of a whole system and not in an isolated manner. Furthermore, we are very cognisant of the need for any new organisation to walk before it can run.

Powers

We therefore have recommended that the Agency not be vested with powers and duties currently held by the Minister, CMOH, Board of Health and MOH. Vesting the Agency with these powers early on in the mandate would not only be a piecemeal approach, it would also be premature. The vesting of powers is always premised upon the capacity to exercise them. This is a challenge

for an Agency yet to come into being and, for this reason, we do not recommend that supplementary powers or reporting obligations be created when the Agency is first established.

The AITF recommends that no specific additional powers be vested with the Agency at this time for both practical and philosophical reasons. The responsibility and authority to take action in response to a health risk is currently vested first and foremost at the local level, and we see no reason to change this. Public Health Units are close to the communities they serve and are best placed to be able to take such action locally to prevent a threat from escalating. In this regard, we concur with the observations of Justice Campbell that the role of the Agency is not to supplant existing authorities but to support and supplement the ability of the system to act locally and regionally, as required.

Reporting

The question of where and to whom the reporting of infectious diseases should occur has been discussed by the AITF. The existing regime is clearly dated and in need of reform both in terms of who is required to report to a Public Health Unit and which conditions they are required to report. However, the basic philosophy is correct and we see no reason to recommend changing the underpinnings of this regime.

With regard to reporting centrally from the Public Health Unit to the MOHLTC, while we have recommended that the Agency have a mandate for surveillance, we would suggest that dual formal reporting or split reporting is not operationally feasible or desirable for reportable diseases.

At this stage, we would recommend that formal reporting remain as is required under the HPPA, from the Public Health Unit through to the MOHLTC. However, this does not imply that there is no role for the Agency in supporting and supplementing epidemiological analysis of reported information. This should be undertaken using a single common data set, with supplemental analysis being undertaken by the Agency as required. We suggest that a more appropriate time to re-examine this question would be after the Agency's first three years of full operation.

Authority to Collect, Use and Disclose Personal Health Information

The role of the Agency in undertaking surveillance activities, laboratory testing and epidemiology will, of necessity, require that the Agency have in place appropriate designation under both the *Personal Health Information Protection Act* (PHIPA)[3] and the *Freedom of Information and Protection of Privacy Act* (FIPPA).[4]

Ability to collect use and disclose Personal Health Information (PHI), ability to share information between the Agency, Ministry and the field, should also be undertaken in a manner that authorises the disclosure of PHI to the Agency for the purpose of meeting its objectives while binding the Agency to having in place the policies and procedures required to guarantee the security of this information.

To this end, it is recommended that the Agency, as a matter of good business practice, agree to a review of its policies, procedures and practices by the Information and Privacy Commissioner within the first three years of its operations.

Authority of the CMOH to Activate Agency's Involvement

Recognising the need for clarity in both emergency and exigent circumstances, it is recommended that there be specific legislative provisions put in place to ensure that in emergency or exigent circumstances, the CMOH is vested with the appropriate authority to activate the Agency to provide assistance that is or may be required. In the context of an emergency situation, equivalent provisions will need to be in place to ensure that the Agency functions within an overall health sector response structure.

Laboratory Services

In anticipating the recommending Agency role with regard to laboratory operations, it is proposed that existing legislative regulatory requirements regarding sample transfer to the OPHL be retained and remain unchanged. Upon completion of the recommended review of the testing mandate, this issue may require reconsideration.

Chapter 6

Ontario Public Health Laboratories

Introduction

The Ontario Public Health Laboratories (OPHL) form one of the larger public health laboratory systems in North America. The system consists of a central laboratory located in Toronto and 11 regional public health laboratories across Ontario. The Ontario system is also a central part of a national public health laboratory network which includes public health laboratories in other jurisdictions and the Level 4 National Microbiology Laboratory in Manitoba.

Over 600 staff in the OPHL perform over four million laboratory tests annually diagnosing diseases, such as tuberculosis, AIDS, SARS, hepatitis, influenza, and West Nile virus and testing drinking water from private wells.

While we often think of laboratories in narrow terms, such as simply performing tests on samples, the OPHL are in reality first and foremost providers of information.

Laboratory generated information informs diagnostic, clinical and public health decision making right across the health system. For the public health system, the laboratories play a vital role in infectious disease surveillance, supplying the test information required locally and provincially to assess the nature and spread of a disease.

There is a long history of public health laboratory services in Ontario; the first public health laboratory grew out of initiatives undertaken at the beginning of the twentieth century by the then Ontario Board of Health, the precursor to the MOHLTC. For many of these early years, there was an extremely strong affiliation with research and with the University of Toronto, in particular. Today's Connaught Research Laboratory shares a common genealogy with the OPHL.

Even up to two decades ago, perhaps less, the OPHL maintained this emphasis on research and was internationally renowned for the studies undertaken, for the testing methodologies developed, and for its general contribution to the field of laboratory science.

That reputation has eroded over the years for a range of reasons:

- Intense funding challenges in the 1990s;
- Increasing imbalance in the competitiveness of salaries for senior-level medical, scientific, and technical staff; and
- Changes in the emphasis and shifting priorities set by different governments on:
    - Public health in general; and
    - Direct research at the laboratory level, in particular.

The net result is that today the OPHL faces a series of very significant challenges. These have been at least partially documented in a range of federal and provincial reports undertaken in the aftermaths of SARS and the recent Legionnaire's outbreak. Some of the more pressing challenges are laid out below.

Recruitment
The OPHL today is faced with a pressing shortage in certain critical areas of expertise. This is most acutely felt in those professions in shortest supply, particularly microbiology. The challenges in attracting medical microbiologists, scientists, and medical laboratory technologists to the OPHL are acute and have been for a number of years. Competition is greater for the qualified individuals that do exist and the OPHL has struggled to keep pace with the conditions of employment in place for certain positions in academic health sciences centres and other research centres both within Ontario and nationally. This imbalance is not only shown in terms of remuneration levels for certain positions, but in terms of the culture of research and innovation that many leading scientists now actively seek out when choosing where to work.

Physical Infrastructure
The current physical plant of the both the existing Central Public Health Laboratory and at least two of the regional laboratories are aging and in need of significant upgrading. In the case of the Central Laboratory, facility age, layout and location of the site mean that regardless of any recommendations from this Task Force, ongoing additional expenditures will be required over the coming years simply to maintain the Central Laboratory.

Information Technology
In an era where the timeliness of test results is critical, in which more and more laboratory testing is automated, the OPHL operations lack a single integrated Laboratory Information System (LIS).

This raises a series of challenges, not least of which is the high level of manual recording and reporting of test data at OPHL, as well as the duplicated effort put into data entry by health care facilities reliant on test data from the laboratory.

This situation results in a number of issues: delays in test results needed for patient care, duplicate testing, and challenges in coordinating data for trends, outbreaks and epidemiological analysis. This is not only a vulnerability; it is neither cost-effective nor time-efficient for the system.

The renewal of the OPHL is, therefore, not simply a question of operational alignment with the Agency; this must go hand in hand with a process to implement a modern integrated LIS.

Testing Mandate
The testing mandate of the OPHL has grown over many decades by both conscious choice and through happenstance. In some cases, the OPHL took on particular tests because, at the time, it was the only laboratory with adequate capacity. In other cases, it was the expedient choice. In yet other cases, testing has in effect been off-loaded from the acute care sector to the OPHL.

The net result is that, in 2006, the OPHL is currently undertaking certain tests which are now routine tests, and the focus upon emerging diseases, confirmatory testing and upon developing approaches to testing for novel pathogens, the core mandate of the OPHL has been weakened. A component of modernising the OPHL, therefore, involves not simply improving how work is performed, but what testing is appropriate.

Viewed together, this constellation of factors points to an organisation that has functioned under less than ideal circumstances for far too long. In part, we have likely achieved the position we are in today because of the relative invisibility of laboratory functions in the face of far more visible and loud demands for scarce resources for other parts of the system. It is time for us to make the laboratory more visible.

Most recently, the CMOH's 2005 Annual Report presented to the Legislature in January 2006 stated plainly:

"In Ontario, the staff at both the central and regional public health laboratories have been called upon repeatedly in crises over the past decade to perform massive test volumes rapidly for Public Health Units and health care providers. SARS, West Nile, and tuberculosis in Toronto's hostel system are but a few examples. The ability to rise to these challenges reflects the tremendous effort and dedication of the professional and technical staff within the public health laboratory, not withstanding the chronic and increasingly urgent need to stabilise and strengthen these facilities."[1]

As stated by the CMOH, there is an urgent need for renewal, as well as an acknowledgement that the system and the people who work in it have risen to the challenge many times.

The real challenge we see is reshaping, re-equipping and re-focussing the OPHL so that the individuals working in that system are enabled with the tools, processes and support that they require and that we require of them, not just to cope with challenges, but also to feel valued and to excel.

Modernising and strengthening the role of the OPHL will not only help us be better prepared to identify infectious and communicable disease outbreaks across the province, but it will also benefit the system as a whole.

We see that part of the route to rebuilding the OPHL lies in deepening and strengthening the emphasis and opportunity offered by research and academic partnerships. Ironically, these were the very conditions that actually fostered the growth of the OPHL in the first place, and returning to these values is a core part of renewal.

The OPHL and the Agency

Creating a new vision for the OPHL, recreating the OPHL as a centre of research and innovation for the future can only be aided through convergence of the OPHL, with the proposed Agency. It is for this reason that we propose the Agency incorporate the responsibility for the operations of the OPHL under the auspices of the Agency. This approach is consistent with the organisational approach increasingly in place across public health agencies globally and would we believe serve the Agency well. See Figure 10 for a description of laboratory services in public health agencies in other jurisdictions.

There are several clear benefits that would result from the transition of the OPHL to the Agency.

- The transition to the Agency would address the current organisational split identified in the Walker Report, between public health and the OPHL[2]. In addition, the OPHL would have the benefit of going from being a small voice in a large Ministry which is not focussed first and foremost in direct service delivery, to being a vital component of a smaller and more focussed organisation with a complementary mandate.
- As has been stated in multiple other reports, the shift would facilitate a far greater link with the related work areas of surveillance and epidemiology.
- We see the move as also improving access and links to external research expertise and within the system, creating the conditions for rekindling the research focus and thereby creating the conditions to address the critical recruitment challenges now faced.
- Through the focus on linkages and affiliations proposed for the Agency, we see immense potential for innovative scientific partnerships such as with the Ontario Veterinary College, University of Guelph (e.g. for zoonotic diseases, such as Methicillin Resistant Staphylococcus aureus (MRSA) transmission from domestic animals to humans), and, over time, in the pursuit of joint or shared research agendas with comparable centres or agencies in Canada (e.g. BCCDC and INSPQ).

These opportunities provide the foundation and rationale for the AITF to recommend integrating the OPHL into the organisational domain of the Agency.

Phased Transfer

The AITF recommends a phased transfer of the OPHL to the Agency by 2008. The AITF had originally considered only recommending that certain components of Central Public Health Laboratory functions transfer to the Agency with the Ministry retaining routine testing procedures. This approach was revised based on further analysis and the Task Force has concluded that partial transfer would be largely unfeasible and operationally divisive.

OPHL testing currently undertaken in the regional laboratories is not based solely on geographic location but rather is shared between regions. Furthermore, the Agency will rightly be expected to serve the needs of all of the Province. It will, therefore, require province-wide surveillance data, access to data and reference testing capabilities.

The AITF believes that it is important for the OPHL to remain intact; dividing the OPHL could fragment an already challenged system and would not enable either the OPHL, or the Agency to fully meet their needs.

The AITF has also considered the timing of any proposed transition, recognising the complexity and care that will be required in realigning the OPHL under the organisational authority of the Agency, while continuing to provide a vital service in the midst of reform. If this approach is to be fully pursued it will take careful planning and implementation and dedicated transitional resources over and above the base costs for the Agency.

	BC Agency for Disease Control	Institut national de santé publique du Québec	US State Public Health Laboratories	UK Health Protection Agency (England & Wales)
Authority and Role Delineation	Legislation, regulation	Legislation, regulation	State legislation and regulation CDC contracts	Legislation, regulation
Laboratory Organisation (Note: Levels of involvement vary)	BC Agency for Disease Control (BCCDC) is an agency of the Provincial Health Services Authority.	Institut national de santé publique du Québec (INSPQ) is an arm's length government institute and includes the: • Québec Public Health Laboratory; • Centre d'expertise en dépistage (Screening Expertise Centre); and • Centre de toxicologie du Québec (Québec Toxicology Centre).	Part of State Departments of Health, there may be several sites.	Public Health Laboratory Service is part of the new Health Protection Agency (HPA); testing is done in the Central PHL, several of the regional PHLs around the country: • 14 sites (total of 22 labs).
Surveillance and Epidemiology	Part of BCCDC	Part of INSPQ	Part of State Departments of Health	Part of HPA, each laboratory carries out functions for its designated pathogens.
Additional Roles	Training for technologists, medical residents and scientists Research and development Allow staffing flexibility from environmental bacteriology to create surge capacity to meet increased workloads.	Health study and surveillance Research and development International cooperation and training which includes: • teaching and training positions; • seminars, symposiums; • continued training; and • improvement of basic public health training.	Varied training Research and development	Training for technologists, medical residents and scientists Research and development A wide variety of scientific and medical staff
Field Support		Use capacity created in legislation (Public Health Act).	Using capacity created through agreements with local PH, clinical laboratories and through Laboratory Response Network (bio-terrorism).	Using capacity of central and regional laboratories.

Figure 10. Laboratory Services in Public Health Agencies

The AITF recognises the magnitude of this undertaking and proposes the immediate establishment of a Laboratory Transition Team (the role of which is expanded upon further in this section) to aid in planning for the successful realignment. It recommends that the following be in place, or well underway, before transferring the OPHL to the Agency:

- Agency established as a legal entity under legislation;
- Agency's founding Board in place (see section on governance);
- Areas of specialisation and functions in place, with a defined and structured operational and management support capacity in place to allow the OPHL to smoothly transition to the Agency;
- A fully developed human resources plan in place and accepted by all parties, allowing for the transfer while maintaining continuity of service and staffing stability; and
- LIS planning and funding secured. Initiation of this critical piece of work should be a key priority. It is therefore important that the groundwork and financial commitments are in place early to assist the Agency in modernising operations.

To achieve these pre-conditions, the AITF recommends a phased approach to transitioning the OPHL to the Agency.

Revitalisation of Ontario's Public Health Laboratory System
Immediate Activities Required
Phase 1
(06/07)
1. Transition Team established
2. Space for re-located testing, identified, designed and secured for Agency/core central laboratory functions
3. Agency Board, laboratory operations and leadership positions secured and in place
4. Funding fully secured for Laboratory Information System implementation
Phase 2
(07)
1. Transition plan agreed to by all parties
2. LIS implementation underway
3. Laboratory service policies, procedures and supports fully in place at Agency
4. Regional laboratory physical plant upgrades underway
Phase 3
(07/08)
1. Physical relocation of core central laboratory services to Agency
2. Operational responsibility transfers to Agency
3. Testing menu review initiated
4. Agency research partnership agreements in place
Immediate Activities Required

Figure 11. Revitalisation of Ontario's Public Health Laboratories

Phase 1 – Immediate Laboratory Activities Required

Establish Laboratory Transition Team

The AITF recommends that a team be put in place to lead the transition of the OPHL , as part of the overall Agency implementation team, with dedicated staffing and access immediate expert resources in key areas to assist with:

- Workforce strategy and planning;
- Logistics associated with the acquisition and move to new laboratory space for core Central Laboratory functions;
- LIS;
- Test mandate criteria;
- Long-term vision planning;
- Financial planning; and
- Project management.

Once the Transition Team is in place, a detailed phased implementation agreement should be prepared, forming the basis of the final plan to be brought forward to the first Board of the Agency and the MOHLTC for adoption.

Establish the Agency as a Legal Entity

The Agency can only begin to play any direct role once it is established as a legal entity with a Board of Directors and core early staffing in place. Once in existence, a key priority in the initial year of operations of the Agency will need to be the creation of an infrastructure to support corporate, administrative and human resources activities required to ensure the OPHL's smooth transition period. As such, both transitional support and early action on the part of the Agency to have in place senior staffing experienced in laboratory operations will be required to meet these ambitious timeframes.

Co-Location of Select Testing Functions with the Agency

The Walker Report had originally recommended locating the Central Public Health Laboratory within the Agency.[3] The government supported this recommendation through commitments made in *Operation Health Protection.*[4]

In taking this step, the AITF wishes to highlight several factors which should be considered in undertaking this transition. The location should:

- Provide easy direct access to Ministries, to the CMOH, the Emergency Management Unit (EMU) and other critical service partners;
- Improve the ability for access and collaboration with the research and scientific communities nearby; and

- Assist in promoting a stronger research and innovation focus through increased links and collaboration with the academic health sciences centres.

Begin Implementing the Laboratory Information System

The physical co-location of core components of testing currently undertaken at the Central Public Health Laboratory is one mechanism of strengthening the linkages required between public health and the OPHL. Equally important, however, is early action to improve the cohesion and ability to share data electronically among the components of a highly decentralised OPHL, as well as between the OPHL and its clients.

The norm across Ontario for the acute care sector and the broader laboratory system is the use of an LIS to manage data pertaining to tests undertaken. The fact that the OPHL currently does not operate with an LIS poses operational and practical challenges which mitigate against the best use of resources and the most timely provision of information to clients.

As time goes on, and the MOHLTC moves to support improved linkages between laboratories through the province-wide OLIS project, the OPHL will be unable to link to OLIS due to the absence of a single integrated LIS at the OPHL.

A clear early requirement to be executed between the MOHLTC and the Agency is to ensure that an LIS is developed and implemented to support laboratory modernisation. Transporting components of laboratory testing to a new facility cannot possibly achieve the goals we all expect without ensuring that the OPHL, as a whole, is equipped to act as a system and communicate in a timely and effective way with other health care partners.

Phase 2 – Regional Public Health Laboratory Renewal

The physical plant challenges faced by the Central Public Health Laboratory are also faced by a small number of the regional laboratories. Three sites face existing challenges with physical space that is aging and requires replacement.

Decisions associated with regional laboratory renewal will need to be faced regardless of the creation of the Agency. Attention to physical plant needs in London and Thunder Bay should be a priority area of focus. In undertaking the regional renewal, it is suggested that close attention be paid by both the MOHLTC and the Agency to locating regional functions to support better linkages with appropriate academic health sciences centres and other centres of concentrated expertise (e.g. in zoonotic diseases). The future Agency and MOHLTC are also encouraged to examine in detail the concept of developing more specialised regional centres.

Phase 3 – Long-Term Revitalisation to Support the Agency's Mandate

Overlapping with the immediate changes to modernise the OPHL is the longer term vision for the future of the OPHL in Ontario. The AITF recommends a number of key components that will help create a strengthened OPHL.

Restructuring Regional Laboratories into Centres of Excellence

The AITF recommends that three regional centres of excellence be created by restructuring the regional laboratories. There should be medical and scientific staffing in microbiology and in specialised diagnostics in these key regional locations and all other locations should have access to this medical and scientific leadership on a coordinated basis.

Review of Testing Mandate

In modernising the OPHL, there is also the clear need to review in detail current testing that is undertaken and determine whether this is still the appropriate testing mandate. We would clearly see this work as being undertaken not by the Agency in isolation, but in partnership with the MOHLTC and others. As part of renewing the OPHL in the coming years, there is also going to have to be a far clearer vision and criteria established articulating what attributes a test must have for it to be an OPHL test. We would envision that this review would identify specific criteria for the new testing mandate. Further, should any tests be determined to be outside the OPHL's mandate, then terms, conditions, quality assurance and data transfer requirements would have to be in place before the OPHL would cease testing in any area.

The review of testing needs to be undertaken from two screens: a) appropriateness and fit with an OPHL mandate and b) an assessment of the test results (e.g. data capture) that would still be required for the purpose of ongoing surveillance purposes. Certain areas of testing may now be considered routine and not a suitable focus for the OPHL. That said, the data generated by these

tests may well have significant importance for overall monitoring purposes. For this reason, care and attention will be required in ensuring that data loss does not accompany changes to the testing menu.

Completion of Relocation

In this phase, we anticipate that the physical re-location of core OPHL functions to the Agency would be completed, with a component of Level 3 laboratory capacity retained at the existing site. At this stage, we would anticipate the full operational transfer of the system to have been completed.

Chapter 7

Support in Emergency and Exigent Circumstances

Context

The AITF has spent considerable time in mapping out the specific place of the Agency within the overall emergency management framework currently in place in the MOHLTC and in the Province. The AITF has been extremely cognisant of the lessons learned from SARS, especially for the need to have clear role definitions. As such, the AITF has tried to ensure that recommendations for the role of the Agency in providing support in an emergency or exigent circumstances would fit into the existing framework and that the chain of command would be clear.

The word 'emergency' has a defined meaning in statute (*Bill 56: An Act to amend the Emergency Management Act, the Employment Standards Act 2000 and the Workplace Safety and Insurance Act, 1997*)[1] to describe situations that constitute danger of major proportions that could result in serious harm or damage. However, there are instances such as outbreaks, localised incidents or other exigent circumstances, which fall short of a formal declaration of an emergency at both the provincial and local levels, but where the expertise of the Agency may still be required. The AITF, therefore, has used the phrase, 'support in emergency and exigent circumstances' to cover situations where in the opinion of the CMOH, the situation is below the level of a declared emergency but would warrant activating the assistance and support of the Agency.

Under the auspices of the Ministry of Community Safety and Correctional Services (MCSCS), Emergency Management Ontario (EMO) provides overall monitoring, coordination and leadership for emergency management in the Province. While EMO has specific skills and expertise in emergency management coordination, it often works closely with other Ministries in order to obtain specific areas of content expertise. As such, the Ministry of the Environment would need to play an important role in chemical spills, the Ministry of Natural Resources for forest fires and the MOHLTC for an emergency that has health sector impacts.

Since SARS, there has been considerable progress in the area of health sector emergency management. Within MOHLTC, the EMU has been established with the responsibility to coordinate the Ministry's planning and response to health related emergencies. The EMU is part of the Public Health Division and reports to the CMOH/ADM of Public Health.

The AITF recognises the value in the work undertaken by the province and MOHLTC in improving readiness and responsiveness to emergency situations. The AITF does not see the Agency duplicating work that is being undertaken but rather sees the Agency as a vehicle to supplement and support the Province in its emergency planning and response by providing improved access to a broader range of scientific and technical areas of specialisation on an organised, permanent and ongoing basis. In addition to deepening the pool of support resources available, the Agency could also play a role in facilitating scientific partnerships in the areas of risk analysis and modelling, as well as being available for deployment and direct field support, when required.

In its Part One Report, the AITF provided a brief outline describing the proposed role of the Agency in emergency management support. The following roles were proposed for the Agency to undertake to support the management of an emergency:

- Support hazard, risk and vulnerability assessments;
- Participate in mitigation and preparedness activities;
- Provide back-up response capacity, which could include human resources and technical resources such as diagnostics;
- Provide access to technical and scientific expertise and support during an emergency; and
- Support planning based on lessons learned from an emergency.

The Task Force emphasises that the Agency's role in an emergency is to provide support, not to lead. The AITF sees the Agency as providing support and operating within the single chain of command via the IMS structure, in place through EMO and, in the case of the MOHLTC, the Executive Emergency Management Committee (EEMC).

Current Emergency Management Structure in Ontario

Emergency Management Ontario

The EMO, under the mandate of the MCSCS, coordinates overall emergency management in the Province of Ontario. The EMO takes a leadership role during large scale, Provincial emergencies and a support role for local emergencies where primary responsibility and authority for managing emergencies are at the municipal or regional level. EMO is responsible for the promotion, development, implementation and maintenance of emergency management programs throughout Ontario.

MOHLTC's Emergency Management Unit

The EMU supports emergency management activities within the MOHLTC and the health care system. The EMU is part of the Public Health Division and reports to the CMOH/ADM of the Public Health Division.

The mandate of EMU is to:

- Identify and develop the infrastructure required to ensure sustainability of emergency readiness;
- Identify and coordinate the business continuity plan for the MOHLTC;
- Develop Ministry emergency readiness plan(s) and response protocols that are consistent with EMO's expectations and MOHLTC and health care system needs; and
- Ensure Ministry emergency plans are transparent with clear accountabilities within the health care system and with Ontarians.

Executive Emergency Management Committee

The MOHLTC has established the EEMC with the Deputy Minister of Health and Long-Term Care as its chair, and includes the CMOH, Director of EMU, EMO liaison, and others. We recommend that there is value in having the Agency represented by the CEO on the EEMC. This would serve to formally link the capacity and resources of the Agency to a single response structure directing the spectrum of activities within the health sector.

The Agency's Support Function within an Emergency Command Structure

The EMO and the EMU currently draw upon external experts as required to help shape and inform the development of specific processes and protocols. The AITF suggests that the Agency's role would be to provide on a formal basis a larger pool and range of specialised scientific and technical skills related to the health aspects of an emergency.

The AITF recommends that the Agency's support role in emergency and exigent circumstances include:

- Provision of scientific advice and technical expertise to support and enhance emergency capability before, during and after an emergency;

- Identification of trends, unusual occurrences, modelling of risk analysis and identification of potential health threats based on surveillance activities;
- Conducting research into the science of emergency management to augment best practices;
- Expanding provincial capacity in modelling related to outbreak response planning; and
- Providing field support capacity as required and when triggered in an emergency or exigent circumstance.

This proposed role would serve to augment the infrastructures already in place at the EMO and EMU. The Task Force recommends that an Office of Emergency Management Support (OEMS) should be created at the Agency to provide internal leadership and external support for emergency preparedness and support activities. Although not employing a large number of staff, this Office would provide the MOHLTC with a single window of access to ensure that appropriate liaison and alignment is in place. We would view the Agency's OEMS being engaged not only during emergencies, but also in providing valuable capacity in engaging with others in the crafting of strategies for prevention, mitigation and preparedness. The responsibilities and expectations for local response and planning should remain at the local level.

As mentioned above, the AITF sees the Agency providing a supportive role not only during emergencies but also during outbreaks and other exigent circumstances where in the opinion of the CMOH, the situation is such that it warrants the directed assistance and support of the Agency.

The AITF recommends that the Agency function in all external emergency and exigent circumstances within the IMS chain of command. In circumstances outside of a formal local or provincial emergency, the Agency would be redeployed at the initiation of the CMOH, who would provide the link between the MOHLTC's EMU and the Agency. When Public Health Units and MOHs need on-site assistance in exigent circumstances, the CMOH would be in a position to ensure the provision of this support through the Agency. This arrangement would also be buttressed by mutual notification requirements between Public Health Division staff and the Agency. The AITF recommends that the Agency, as an early priority, have in place formal redeployment protocols and procedures that are developed in conjunction with the the MOHLTC and CMOH and ensure that these are coordinated with others.

In order to ensure that the Agency is able to provide support in an emergency or outbreak situation as well as redeploy staff, the AITF recommends that there be a mechanism in place to ensure supplementary funds can be readily made available equal to approximately three months of the Agency's operating budget. These funds would need to be readily available in order to:

- Cover services, supplies and equipment in an emergency or outbreak;
- Allow for business continuity and project commitments to be met; and
- Cover excess costs associated with redeployment (travel, accommodation etc).

If this contingency fund were held by the MOHLTC, in order to ensure accountability, the access to it could be under the authority of the CMOH and linked to the instances where the CMOH used his or her authority to direct the Agency to deploy staff or otherwise participate in an emergency or outbreak.

The Agency's Support Role

Although the EMO describes the phases of the emergency management framework as: preparedness, prevention, mitigation, response and recovery, the Task Force finds it useful to consider the Agency's role in emergencies to be in three phases: before, during and after the event.

Before Event Activities – Modelling Risk Analysis and Reciprocal Notification

Activities before an event are primarily focussed on preventing or minimising the impact of a health emergency. Risk assessments are the first step in the process. Before attempting to mitigate or plan a response to a potential threat, the threat must be identified and its potential risk assessed. Any threats identified can then be prioritised based on their probability of occurring and potential impact.

Identifying and assessing possible risks to the health of Ontarians frequently depends upon epidemiologic and surveillance data. Currently, this type of information is available in Ontario but there are areas that clearly require strengthening. The Agency's added value would be to:

- Expand the scope of surveillance activities into areas where such activity is currently limited, e.g. facility-acquired infections;

- Strengthen links between animal and health surveillance;
- Expand capacity to do detailed modelling and risk analysis;
- Take epidemiological data from multiple sources and cross-walk it between data sets to be able to identify trends or unusual occurrences before they become widespread in the population; and
- Examine and assess potential opportunities for non-traditional surveillance (e.g. potential use of pharmacy sales data to identify unusual peaks in demand for anti-diarrhea medication that could indicate a water- or food-borne pathogen).

A timely example is preparedness for a potential influenza pandemic where significant progress has already been made. In planning for a complex emergency with many unpredictable factors such as a pandemic, access to well developed modelling capacity is useful to test and retest potential plans as more information becomes known. Improving our capacity to undertake this sort of work might assist in informing who might be most affected by an outbreak and how best to deploy potentially limited supplies of medications. This capacity is currently being developed in a number of jurisdictions and is one area of activity for which the Agency can play a valuable key role. In addition, Ontario has, based on the experience from SARS, valuable information and experience that could be harnessed to better anticipate the psychological dimensions of response which drive the behaviour of public health practitioners and health care providers. The focus on behavioural science would assist in this regard.

The co-location and incorporation of OPHL with the Agency should also assist in building a quicker transfer of test information to Ministry and Agency experts especially when coupled with the implementation of an LIS.

The science and best practice of incident management and emergency preparedness in general are also both fairly new to the health care and public health fields. Several of the areas of specialisation proposed for the Agency include knowledge exchange and research support. These areas could play a valuable role in supporting existing efforts to assist organisations building emergency preparedness into their practices as part of an overall plan.

The Agency's Role in a Long-Term Care Facility (No Emergency Declared) Respiratory Outbreak

A respiratory outbreak occurs at a long-term care home in a medium sized municipality. Many residents and staff from the long-term care home have fallen ill and there have been several deaths. The Public Health Unit calls the CMOH for assistance. The CMOH directs the Agency to help.

Before the event, support provided by the Agency could include:

- Enhancing surveillance capacity;
- Providing training supports for long-term care home staff in infection prevention and control best practices; and
- Providing scientific and technical support to improve screening tools available to long-term care homes.

During the event, once called upon by the MOHLTC through the CMOH, Agency support roles could include, as required:

Communications

- Knowledge exchange staff could support the information officer on site.

Operations

- Clinical staff could support on-site clinical staff involved in treatment;
- Infection control experts on staff or in Agency advisory committees could provide recommendations and technical support on containment; and
- Laboratory staff could perform tests on samples to identify the pathogen that has caused the outbreak.

Planning

- Clinical experts could provide recommendations on treatment strategies; and
- Agency staff could provide technical support for data collection, analysis and reporting and other epidemiological activities locally or provincially.

Finance/Administration

- Agency staff could support administrative activities.

Reciprocal Notification

As mentioned earlier in this Report, it is recommended that clear communication protocols be in place between MOHLTC and the Agency and that these be spelled out in an MOU and include partner Ministries' requirement for reciprocal notification of unusual events. These protocols should also outline how the MOHLTC, through the CMOH and the Agency ensure that there is timely mutual notification of unusual events through surveillance, reporting or exchanges with the field. This is important so that early expertise, technical advice and support can be provided before a situation escalates. This mutual notification will assist in ensuring that both the CMOH and the Agency are aware of any unusual occurrences and that action can be taken in a coordinated manner early to mitigate threats. As the Agency becomes operational, these protocols will need to be reviewed and refined on an ongoing basis.

During Event Activities – Communication, Protocols, Re-Deployment and Field Support

In its early days, the Agency should focus on ensuring that its processes and plans for working effectively with others are developed early and widely understood. These processes and plans must also be regularly tested and reviewed with key partners, continually kept current and clearly conveyed to all affected parties. It is recommended that the Agency should be structured with the ability to redeploy staff for rapid on-site field support in an emergency, when directed.

Communication

The Agency could be called upon by the MOHLTC to provide the scientific and technical information to support the Important Health Notices that are released by MOHLTC during an outbreak. As well, the Agency could also play a valuable role by participating in devising the guidance materials/directives to help support the field during an outbreak. This is in keeping with its support role within the overall framework.

In times of emergency, it is not recommended that there be multiple advisors functioning in isolation. As such, the role of the Agency in providing technical advice should be part of a clearly established process worked out in advance and activated as part of an overall framework. In order to ensure that information is consistent, the Ministry, in the past has set up a central number to call to assist the field with technical questions. It is not envisioned that this will change. As such, a joint approach to call triage should be used to manage such circumstances.

After Event Activities – Contingency Planning, Lesson Learned

The recovery process leads back to mitigation by implementing policies to prevent similar occurrences in the future. The AITF would envision the Agency being drawn upon where required as both a participant in post-event debriefings and by participating as required in recovery activities.

Synopsis of the Agency's Role

- The Agency would not have a mandate to be a primary response agency in an emergency but can be triggered by the EEMC to provide support when local officials do not have the resources in place or available regionally to manage the incident without external assistance.
- Support for responses to emergency or exigent circumstances could involve deploying Agency staff to the field to help local officials manage the emergency. Support may also involve internal activities such as increasing laboratory capacity to deal with an increase in the volume of samples or to aid in diagnosing an unknown agent.
- Should the Agency staff be redeployed to the field, they should be networked to support and integrate into the local response structure and not displace local command and control structure.
- While the Agency will not subsume the responsibility of other primary agencies to manage the emergency, its staff shall be expected to work alongside other agencies at all levels within a single coordinated IMS structure to execute an effective response.

Chapter 8

Phasing-in

As part of its deliberations, the AITF discussed priorities for phasing-in, over a three-year period, from both an organisational start-up perspective and from a functional perspective. These priorities are outlined as a high-level Implementation Plan for consideration by the Agency and the MOHLTC in the coming months. The AITF, in its advisory capacity, is not in a position to make final determinations on the timing and priority placed upon various components. The task of adopting a Strategic Plan for the Agency would require consideration by the founding Board and CEO, in concert with the appropriate Ministries and the priorities emerging at the time in the field. We do, however, offer our advice on what a roadmap for implementation could look like. On this basis, we would see the following markers ahead.

Priorities for Agency Start-Up

The priorities to establish the Agency should be first thought of as building the organisation's foundation. Without certain basic organisational structures and processes in place, the Agency cannot begin its operations or meet its mandate. While these tasks may appear largely internally focussed, the reality is that they are the rudimentary steps that any new organisation has to go through and they will have to occur to start the Agency on stable footing.

Upon receiving the legal status of an Agency, the following activities should be in place in the first two years of the operations:

In order to support the Agency in undertaking these activities, the MOHLTC will also have key responsibilities which include:

- Providing transitional assistance in set-up;
- Establishing the Intra-Ministry and Inter-Ministry Committees responsible for identifying Provincial priorities for the Board's consideration;
- Reviewing and approving the Agency's Business Plan and budget;
- Undertaking alignment planning within the Public Health Division to address the operational liaison requirements and assessing project specific areas which may be better undertaken by the Agency; and
- Establishing appropriate protocols regarding communication and liaison.

Primary Initiatives for the Agency to Undertake

In discussing the potential priority areas for the first three years of operations of the Agency, the AITF recognised that there are clear

Priorities for Agency Start-Up	Year 1		Year 2
	1-6 mo	6-12 mo	
Establish founding Board			
Founding Board recruit, select and hire CEO			
Identify, select and recommend for appointment of remaining Board members			
Board create and approve by-laws, policies, guidelines, etc.			
Board establish Standing Committees			
MOHLTC/MHP establish Intra-Ministry and Inter-Ministry Committees and identify key priorities and activities for a three-year time frame for the Board's consideration			
Strategic Planning Committee of the Board to develop initial Strategic Plan for inclusion in the Business Plan and adoption by the Board			
Audit Committee and Board develop budget for inclusion in the Business Plan			
Board submit Business Plan and proposed budget to the Minister			
Board complete audited financial statement and submit to the Minister			
Board submit annual report to the Minister for tabling in the Legislature			

Figure 12. Sequencing of Recommended Priorities for Agency Start-up: Years 1 and 2

general activities that need to be undertaken in a range of areas. We are very conscious that specific areas of technical activity will be set and shaped by the specific demands and expectations from the Ministries , Public Health Units and the broader health care field at the time the Agency becomes operational.

We have, for example, identified the need for early action to be taken to strengthen surveillance of AROs in health care and community settings, but we cannot predict where the new strains of resistance will occur, in which communities or facilities the next outbreak will happen and what specific guidance and assistance may be required.

It is also anticipated that the public health and health care landscape will change by the time the Agency is fully established and operational. Health care is never static, and that is probably truer today than it has been in many years. The work of the Agency will obviously not be exempted from demands resulting from these changes and will need to adapt as the landscape evolves. This may affect not only what tasks are undertaken but for whom.

For example, we fully anticipate that additional priorities for the Agency will emerge in response to the MOHLTC, MHP, or field needs stemming from initiatives such as the establishment of the LHINs, the report of the CRC, the updating or replacement of the MHPSG in Public Health, the issues and needs identified through the recently established RICNs. All of these activities are either underway or planned now. and all of which will have a direct bearing on what the Agency may be required to address.

Criteria

Given the shifting tides, the AITF recommends that a set of basic criteria be put in place and used as a filter to screen the first areas of work, either generated through Ministries' input or through field identified needs.

Identified Gaps

The degree to which the specific initiative addresses a need identified by the appropriate Ministries or through engagement with the field. For example, enhancing public health surveillance and surveillance products in general have been highlighted as important gaps not only for the field, but also for various levels of government.

Level of Risk

As with any prioritisation process, the AITF suggests considering the level of risk that different initiatives are intended to address. Thus, priorities which are linked to an existing or anticipated public health threat should be identified as key priorities. For example, in an environment where the public's anxiety is growing in anticipation of an influenza pandemic, any initiatives, which could assist and strengthen Ontario's response to a potential outbreak, should be ranked as a first priority.

Consistency with the Mandate of the Agency

The initiatives proposed must be aligned with the Agency's mandate and, as such, vigilance will be required by all involved in ensuring that the mandate of the Agency is respected for what it is and what it is not. This will require discipline and focus from all levels. If the Agency is to be successful, it cannot be asked to be all things to all people.

Appropriateness

The initiatives proposed should also be examined to assess whether the project or task fits as a priority for a Provincial Agency. Over time, there will be a delicate balance to be achieved between responsiveness to identified needs and a possible risk of over-reliance. This may be some time out, but it is a risk that has faced other agencies of this type. There is and will remain a clear need for strong Public Health Units, strong infection control programs across all facilities, better coordination; the Agency will not replace this need. An example in this regard, is getting the balance right in what should be expected of each Public Health Unit and each RICN before it is considered appropriate to draw on central resources.

The following are suggested for the Agency's consideration as primary initiatives to undertake:

Epidemiology and Surveillance

- Synthesis, analysis and dissemination of existing epidemiological data, which might include the development of a more comprehensive version of the Public Health and Epidemiology Report Ontario (PHERO)[1] along with an enhanced frequency of distribution and greater retrospective analysis on temporal and geographic trends where data allows.
- Access to relevant environmental monitoring data from the Ministry of the Environment on pollutant criteria and the quality of air and water. In Years 2-3, this data should be analysed with respect to better understanding health impacts and where possible health outcomes.
- A priority for Year 3 should be the development of an Ontario Health Status Report (OHSR) with the following themes: infectious disease, selected non-communicable diseases, environmental health and population-based analysis, with a particular focus on perinatal and paediatric populations and other groups. The OHSR, developed based on existing surveillance data from multiple sources and upon health indicators and health outcomes, should serve to identify gaps in surveillance and data, including data quality.

In addition to the above, surveillance activities should focus on known gaps and needs in Ontario, including:

- Responding to a range of infectious diseases which are a) currently not reportable b) of increasing impact and c) for which existing surveillance is limited. These would include Clostridium difficile, both facility- and community-acquired strains of MRSA and Vancomycin Resistant Enterococci (VRE) and a number of other nosocomial infections;
- Enhancing, in partnership with others, RRFSS to expand the depth and reach of this valuable data set on chronic disease risk factors; and
- Improving both awareness and linkages between animal health surveillance activities undertaken at a range of levels, such as the Canadian Cooperative Wildlife Centre, the Ontario Veterinary College at the University of Guelph, and the broader health surveillance system.

Emergency Management Support

From the end of Year 1 and throughout Years 2-3, the AITF recommends a focus on the following issues and activities related to emergency management support:

- Developing the required re-deployment and communication protocols and agreements with the CMOH and MOHLTC;
- Establishing effective working relationships with existing structures, and, in particular, the EMU;
- Developing internal IMS framework for the Agency;
- Assessing and evaluating available outbreak modelling capacity; and
- Developing and strengthening links to the field through establishing partnerships and linkages with others.

Research and Knowledge Exchange

The AITF recommends that the Agency undertake the following activities at the end of Years 1-2 to support its research mandate:

- Establishing initial partnership and affiliation agreements between the Agency and academic sector (e.g. colleges, universities, academic health sciences centres) and others;
- Developing in collaboration with the MOHLTC and supporting regional research and knowledge exchange network specific to public health;
- Initiating a three- to five-year province-wide public health research and knowledge exchange agenda of relevance to Ontario public health practice and policy. Using a collaborative and consultation process, this agenda should include strategic directions and priorities for action;
- Undertaking a process to establish field presence to support research, knowledge exchange and professional development;
- Assuming direct oversight for the PHRED Program; and

Priorities	Year 1	Year 2	Year 3
Epidemiology and Surveillance			
Enhance analysis and dissemination of existing epidemiological data findings including developing a regularly enhanced and updated epidemiological bulletin to the field (replacing PHERO)			
Increase access to existing environmental monitoring data and relevant data on environmental health criteria pollutants and where feasible support linkages to existing data sets			
Enhance and expand provincial surveillance initiatives for chronic disease risk factors beginning with RRFSS			
Undertake work to support indicator development for MHPSG			
Undertake a comprehensive Ontario Health Status Report			
Develop ongoing surveillance on targeted nosocomial infections and antibiotic resistant organisms (those currently non-reportable)			
Enhance coordinated laboratory-based surveillance beginning with formal linkage with Animal Health Laboratory and Ontario Veterinary College in Guelph and the Ministry of the Environment			
Initiate assessment of newer non-traditional surveillance methods (e.g. syndromic surveillance and pharmacy data for potential adoption)			
Support in Emergency and Exigent Circumstances			
Undertake a review of existing outbreak/scenario modelling capabilities for potential adoption			
Develop with MOHLTC re-deployment protocols and processes for field support			
Provide scientific and technical assistance as required on emergency risks			
Develop and test communication protocol with MOHLTC			
Research and Knowledge Exchange			
Establish initial research affiliations with core areas of partnerships			
Establish foundational data sharing agreements with MOHLTC, partner Ministries and agencies			
Undertake with MOHLTC the development of the proposed public health research and knowledge exchange network			
Release a province-wide research and knowledge exchange agenda for public health			
Establish field presence to support research, knowledge exchange and professional development			
Undertake specific activities to support the research and knowledge exchange agenda (e.g. training in research methodologies, gap analysis of projects underway, regular priority setting, and consultation sessions)			
Assume direct oversight for the PHRED Program			
Develop and disseminate training tools and supports to assist implementation of updated Mandatory Programs			
Professional Development			
Organise an on-going roster of training opportunities focussed on core areas			
Develop and deliver regular tele-rounds and support tools on best practices in a range of areas of specialisation			
Deliver competency-based tools and training products on infection control for all health care settings			
Implement formal placement and field exchange program			
Information Technology and Library Support			
Assess and implement Agency's information and information technology needs as well as data requirements and library support			

Figure 13. Suggested Primary Initiatives for the Agency to Undertake

- Developing and disseminating evidence-based best practice documents, including guidelines and protocols aligned with areas of specialisation in the Agency and identified needs. Topics may include:
    - Infectious disease (building on PIDAC endeavours);
    - Environmental hazard assessment and response;
    - Best practice models for health promotion interventions in defined areas of need; and
    - Multi-risk factor intervention and research models.

Professional Development

In terms of professional development, the Agency should consider prioritising for Year 1, the development and subsequent implementation in Years 2-3 of workshops, summer institutes, web-based training and support, and other continuing professional education initiatives in partnership with colleges, universities, academic centres, Public Health Units and the Ontario NCC on both general and area specific topics (e.g. sessions on health promotion) and other key themes, such as:

- Research methods and data limitations;
- Core competencies;
- Systematic literature reviews;
- Social marketing; and
- Emerging issues updates.

In addition to formal face-to-face activities, it is strongly suggested that partnerships be in place to support other forms of professional development, such as the Public Health Portal, the broader telemedicine network, and distance and virtual training and information sharing.

Information Technology and Library Support

There is a need to establish library support within the Agency to promote improved access to information, sources, tools and services to a range of users. This can be achieved through the collaboration of the Agency's library with information and information technology in the assessment of network and technology requirements that will address library needs, facilitate data sharing and provide remote access for external users.

While there are a range of areas where new information technology supports will be required to support the Agency in its operations (the most critical being modernising laboratory services). In a number of other areas, however, we would urge that the Agency draw upon and utilise to the extent feasible the investments that have already been made in information technology infrastructure in the Province.

In the area of public health, there is clearly a need for the Agency to link into work underway through the Public Health e-Health Council. This would provide an opportunity for effective synergies between broader system planning and minimise the risk of unnecessary duplication by the Agency. While we would not see the Agency as a deliverer of IT solutions to the broader public health system, there are clearly roles that the Agency could play as a supportive partner in future approaches. As a potential future user of data and information collected and a potential developer of content to optimise the use of existing systems, the Agency will clearly need to be linked to the broader efforts currently underway.

In addition, we would urge that full advantage be taken of the investments that have gone into: data storage capacity through Smart Systems for Health, information management through MOHLTC efforts, dissemination capacity through the Public Health Portal and other such mechanisms. Where these investments can assist the Agency in meeting its objectives, we would encourage both the MOHLTC and the Agency to take full advantage of such opportunities.

In areas where the Agency may require specialised tools (e.g. in the area of outbreak and incident modelling), we would suggest that this be developed with the goal of collaboration and connectivity (with both Ministries and the field) in mind and not as an isolated stand alone solutions.

Funding

Dr. David Walker had, in the final report of the Expert Panel on SARS and Infectious Disease Control, recommended an annual operational budget of $45M[2] excluding existing base expenditures associated with laboratory operations. Dr. Walker had further recommended a $35M capital allocation and an allocation of $3.5M in design and development costs.

We have studied a range of comparable agencies with comparable mandates across a range of jurisdictions. In truth, the budgets for these organisations range broadly based upon a series of factors:

- Degree or absence of direct service delivery;
- Degree or absence of a direct funding role through to state or local health organisations or agencies for the purpose of executing programs; and
- Length of time in existence – typically incremental growth based upon being called upon to address a new or emergent area of work has shaped their growth. This is particularly true with significant infusions of resources at the national level in the UK and US associated with bioterrorism preparedness.

In examining the budgets of the INSPQ and the BCCDC and adjusting for population size, we would concur with the overall proposal put forward by Dr. Walker. For budgeting purposes, the role, mandate and structure of the CDC is of limited use in the Ontario context even adjusted for population. The CDC role in providing direct project-based funding, its close to fifty year history and the sometimes compensatory role that the CDC plays for areas of weak local public health in the US tend to mitigate against its use as a population adjusted comparator.

A range of variables which are outside the responsibility of this Task Force further complicate final approaches to funding. Firstly, and most significantly, until the OPHL review is completed, the costs associated with the recommendations cannot be known. Secondly, the decision and timing of OPHL transition will adjust the overall budget totals significantly.

The phasing-in of funding for the Agency is also contingent, first and foremost, upon the formal creation of the Agency as a legal entity. This is a decision that this Task Force is not in a position to make and will impact the levels and nature of funding required in the first three years. In addition, timing of the appointment of the full board appointment and the hiring of the CEO are also variables beyond the control of the Task Force.

In addition, project reviews, such as the review called for in our Part One Report of the OHPRS, are required to determine what, if any, roles of existing entities funded by the Province in the area of health promotion might be assumed by the Agency.

Acknowledging these significant variables, we would recommend an allocation consistent with the range offered by Dr. Walker but with the following considerations.

- OPHL transition and modernisation costs should be considered as additional costs over and above any base allocation for the Agency.
- Areas of specific project funding which align most with the Agency mandate should be examined for consideration for transfer to the new organisation at a later date. In particular, existing PHAC funding for the NCC in Public Health Tools and Methodologies should be re-assigned to the Agency by 2007/08.
- The Agency should be permitted and indeed encouraged to seek access to third-party funds, particularly in the area of research, to supplement its base allocation without affecting its base funding.

Under the scheme we have proposed, we anticipate the development of both Strategic and Business Plans involving direct engagement on project deliverables between the MOHLTC, partner Ministries and the new Agency. It is through this process and the related accountability provisions that we would see the most rational approach to settling the specific sub-allocations from within an overall funding envelope.

Conclusion

In concluding, we would like to acknowledge and thank all those who have provided us with their advice, support and guidance throughout this process. We have benefited greatly from this input.

Creating a new Agency is an enormous undertaking and will take time to get right. We will need to learn as we go, as those who have gone before us have had to do. We cannot possibly know all of the answers today, nor can all of them be prescribed in advance by this Task Force. Looking back to SARS and forward to the risks that may face us in the coming years, we are in no doubt whatsoever that creating the Ontario Agency for Health Protection and Promotion is the right thing to do for Ontario. That said, this process will need to be a collective endeavour that evolves and is refined over time as the Agency becomes a reality.

We need to forge a new partnership between the way that Ministries, health care providers and researchers interact around the shared objectives of equipping ourselves with the best available knowledge, tools and supports to protect and promote the health of all Ontarians. To do this, we need to harness and draw on the skills and knowledge buried in structures that too often are isolated and disconnected from each other.

We are honoured to have had the opportunity to contribute to this historic undertaking and hope that our work can provide some assistance in meeting some of the challenges ahead. It is our earnest hope that a few years from now Ontario and Ontarians will be justly proud of their Agency and truly see a Province that indeed fully learned from SARS, remembered and acted.

Appendix 1

Terms of Reference for the Agency Implementation Task Force

Background

As outlined in "Operation Health Protection – An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario", the Ministry of Health and Long-Term Care ("MOHLTC") is committed to the establishment of a Health Protection and Promotion Agency ("Agency") by 2006/07. An Agency Implementation Task Force will be struck to provide advice to the Ministry of Health and Long-Term Care on the design, development and implementation of the Agency.

Purpose

The Task Force will advise the MOHLTC on the operationalization of the Agency. This advice will centre on a number of areas such as validation of core activities, organizational and functional operations, development of an implementation plan, relationships with other public health organizations, as well as capital and ongoing operating budget requirements.

Responsibilities

The responsibilities of the Agency Implementation Task Force will be to:

- Validate the Agency's proposed mandate, key functional areas, structure, governance and oversight.
- Recommend operational public health responsibilities for the Agency, and delineate its role and responsibilities in relation to those of the MOHLTC and academia and the broader public health system, the Federal Public Health Agency and its collaborating centres, etc.
- Recommend a comprehensive three-year implementation plan for the Agency (including infrastructure, financial requirements, human resources, transition, arrangements etc.).

The Task Force may wish to establish sub-committees and/or undertake consultations with Ontario health care providers and other stakeholders in developing its recommendations.

Membership

The Chief Medical Officer of Health will appoint the Co-Chairs and the members of the Task Force.

The Co-Chairs will be professionals with recognised public health expertise and experience in the provision of strategic advice. Membership will include provincial and national experts representing the proposed functional areas of the Agency (e.g., research, laboratory, infection diseases, health promotion, chronic disease and injury prevention, etc.) as well as a member with financial expertise.

Accountability

Through the Co-Chairs, the Task Force will report to the Chief Medical Officer of Health and Assistant Deputy Minister of the Public Health Division. An ad-hoc intra-Ministry Committee will be established to liaise with this committee.

Staff Support

The task force will be supported by staff from the Strategic Planning and Implementation Branch (SPIB) of the Public Health Division of the Ministry of Health and Long-Term Care.

Term of Appointment

Task Force members shall be appointed for a term of one year. This term may be extended, upon the needs of the Ministry of Health and Long-Term Care.

Time Frame

The Task Force will complete its work over a one year period, recognizing that the Ministry of Health and Long-Term Care is committed to the establishment of the Agency in 2006.

The Task Force will present interim recommendations to the Ministry of Health and Long-Term Care in the Summer of 2005. A Final Report will be presented in the Fall of 2005.

Appendix 2

Terms of Reference for the Reference Panel

Background

In June, 2004, the Minister of Health and Long-Term Care released Operation Health Protection – A Three Year Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario. This Action Plan confirms the commitment of the Ministry of Health and Long-Term Care (MOHLTC) to implementing the recommendations of the Expert Panel on SARS and Infectious Disease Control as per the following strategic directions:

- Creating the Ontario Health Protection and Promotion Agency
- Renewing the Public Health System
- Health Emergency Management
- Infection Control and Communicable Disease Capacity
- Health Human Resources
- Infrastructure for Health System Preparedness

An Agency Implementation Task Force (AITF) has been established to provide advice to the MOHLTC, via the CMOH, on the design, development and implementation of the Ontario Health Protection and Promotion Agency.

The responsibilities of the AITF will be to:

- Validate the Agency's proposed mandate, key functional areas, structure, governance and oversight.
- Recommend operational public health responsibilities for the Agency, and delineate its role and responsibilities in relation to those of the MOHLTC and academia and the broader public health system, the Federal Public Health Agency and its collaborating centres, etc.
- Recommend a comprehensive three-year implementation plan for the Agency (including infrastructure, financial requirements, human resources, transition, arrangements etc.).

The Co-Chairs of the AITF are Dr. Terry Sullivan and Dr. Geoff Dunkley.

The AITF is creating a Reference Panel (RP) to advise and assist in meeting its mandate.

Purpose

The purpose of the RP is threefold:

- Provide a forum to update public health practitioners/associations on the activities of the AITF.
- Provide a forum for public health practitioners/associations to share their knowledge and expertise relating to public health and issues that emerge from the AITF.
- Provide feedback to the AITF on specific matters related to the development of the Ontario Health Protection and Promotion Agency.

The Co-chairs of the Reference Panel will be Dr. Terry Sullivan and Dr. Geoff Dunkley.

Terms of Membership

1. The RP will have a sunset date of December 31, 2005, unless the AITF and the MOHLTC agree to extend this date.

2. The RP will operate by consensus to the fullest extent possible.

3. The RP members will be reimbursed for travel expenses as per Management Board Guidelines.

4. The proceedings of the RP are intended to occur in an atmosphere where all members, including the Co-Chairs, can speak freely and where discussions and materials shared among the participants are kept confidential and are not discussed or distributed outside the proceedings of the RP. Any reports of the proceedings prepared by the Chair of the AITF will not attribute the contents of the discussions to any person. RP members must respect these confidentiality requirements unless disclosure is required by law. If a RP member believes that he or she may be required to make a disclosure by law, the RP member will notify the Chair prior to such disclosure being made.

5. Participation in the deliberations of the RP shall not be construed as limiting the ability of any organization to make whatever representations they so choose to other processes currently in place.

6. All documentation produced by the RP will be the property of Her Majesty the Queen in right of Ontario.

Support to the Reference Panel

1. The RP will be supported by the Strategic Planning and Implementation Branch (SPIB) of the Public Health Division of the MOHLTC.

Meetings

1. The RP will convene for a minimum of two meetings.

Terms of Reference for the Research and Knowledge Transfer Sub-Committee

Background

In June, 2004, the Minister of Health and Long-Term Care released *Operation Health Protection – A Three Year Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario.* This Action Plan confirms the commitment of the Ministry of Health and Long-Term Care (MOHLTC) to implementing the recommendations of the Expert Panel on SARS and Infectious Disease Control as per the following strategic directions:

- Creating the Ontario Health Protection and Promotion Agency
- Renewing the Public Health System
- Health Emergency Management
- Infection Control and Communicable Disease Capacity
- Health Human Resources
- Infrastructure for Health System Preparedness

Research and knowledge transfer has been identified as a priority for the creation of the Ontario Health Protection and Promotion Agency and in the renewal of the public health unit system.

1. Ontario Health Protection and Promotion Agency

An Agency Implementation Task Force (AITF) has been established to provide advice to the MOHLTC, via the CMOH, on the design, development and implementation of the Ontario Health Protection and Promotion Agency.

The responsibilities of the AITF will be to:

- Validate the Agency's proposed mandate, key functional areas, structure, governance and oversight.
- Recommend operational public health responsibilities for the Agency, and delineate its role and responsibilities in relation to those of the MOHLTC, academia, the broader health, the Federal Public Health Agency and its National Collaborating Centres.
- Recommend a comprehensive three-year implementation plan for the Agency (including infrastructure, financial requirements, human resources, transition, arrangements, etc.).

The Co-Chairs of the AITF are Dr. Terry Sullivan and Dr. Geoff Dunkley.

A core function proposed for the Agency is research and knowledge transfer. *Operation Health Protection* noted that this function would be undertaken through creating, reinforcing and strengthening partnerships with research, academia, and healthcare institutions to support the generation of evidence-based public health policies and practices.

2. Public Health Renewal

One of the key goals of renewing the public health system is to review the organization and capacity of local Public Health Units and the Public Health Education, Research and Development (PHRED) Program. This review will inform the development of long-term strategies to enhance capacity to plan and implement optimal public health programs and services that effectively respond to the needs of Ontarians. This review is being supported by the CRC.

CRC advises the CMOH and, through her, the MOHLTC on options to improve the function and configuration of the local Public Health Unit system. The advice to be provided encompasses the following:

- core capacities required (such as infrastructure, staff, etc.) at the local level to meet communities' specific needs (based on geography, health status, health need, cultural mix, health determinants, etc.) and to effectively provide public health services (including specific services such as applied research and knowledge transfer);
- issues related to recruitment, retention, education and professional development of public health professionals in key disciplines (medicine, nursing, nutrition, dentistry, inspection, epidemiology, communications, health promotion, etc.);
- identifying operational, governance and systemic issues that may impede the delivery of public health programs and services;
- mechanisms to improve performance management systems and programmatic and financial accountability;

- strengthening compliance with the Health Protection and Promotion Act, associated Regulations and the Mandatory Health Programs and Services Guidelines;
- organizational models for Public Health Units that optimize alignment with the configuration and functions of the Local Health Integration Networks, primary care reform and municipal funding partners; and
- staffing requirements and potential operating and transitional costs.

The Chair of the CRC is Dr. Susan Tamblyn and the Vice-chair is Mr. Brian Hyndman.

Purpose

The Research and Knowledge Transfer Sub-Committee will support the AITF and the CRC by sharing its expertise and making recommendations to produce the following deliverables:

- An assessment of lessons learned from existing and former models of public health research and knowledge transfer in:
  - Ontario (e.g., the Public Health Research, Education and Development (PHRED)/ Teaching Health Unit Program).
  - Other jurisdictions (i.e., British Columbia, Quebec, etc.)
- An assessment of gaps and analysis of needs with respect to public health research and knowledge transfer.
- An environmental scan of other key sources of research and knowledge transfer for public health units, such as universities, ICES, CIHI, Health Intelligence Units, Ontario Health Promotion Resource System members.
- Recommendations for an appropriate vision to inform the design of the mandate and structure for a research and knowledge transfer system, including the potential roles of the Health Protection and Promotion Agency, that support and enable more effective public health programs and policies and that is anchored in public health needs.

The Research and Knowledge Transfer Sub-committee will be Co-chaired by Mr. Brian Hyndman, Vice-chair of the CRC and Ms. Jennifer Zelmer, AITF member.

Terms of Membership

1. The Research and Knowledge Transfer Sub-Committee will report to the AITF and CRC via its Co-chairs.

2. The Research and Knowledge Transfer Sub-Committee will have a sunset date of December 31, 2005 unless the CRC, the AITF and the MOHLTC agree to extend this term.

3. The Research and Knowledge Transfer Sub-Committee will operate by consensus to the fullest extent possible.

4. The Research and Knowledge Transfer Sub-Committee members will be reimbursed for travel expenses as per Management Board Guidelines.

5. All documentation produced by the Research and Knowledge Transfer will be the property of Her Majesty the Queen in right of Ontario.

Support to the Sub-Committee

1 The Research and Knowledge Transfer Sub-Committee will be supported by the Strategic Planning and Implementation Branch (SPIB) of the Public Health Division of the MOHLTC.

Process

1. The Research and Knowledge Transfer Sub-Committee will convene at the call of the Co-chairs, Mr. Brian Hyndman and Ms. Jennifer Zelmer.

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